An examination of health visitors' professional judgements and use of formal guidelines to identify health needs and prioritise families requiring extra health visiting support

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Abstract

The aim of this study is to examine health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra support. In view of the potential importance of professional judgement in the assessment of family health need, the thesis begins with a concept analysis of professional judgement in contemporary health visiting practice.

The thesis then describes a national study conducted to examine the validity and reliability of clinical guidelines existing in Community Trusts in England to assist health visitors in identifying families requiring increased support.

In the main study, a case study guided by a constructivist methodology has been adopted to undertake an in-depth examination of how fifteen health visitors working in three Community Trusts identify families in need. Data was collected during 56 observed visits to families receiving extra health visiting support. Following these visits in-depth interviews were conducted with clients and health visitors.

The study findings illustrate that despite an NHS ethos of guideline formulation, an apparent contradiction to guideline development lies in their limited use in practice. Even when guidelines exist, most health visitors use their own professional judgement in making family assessments.

The detailed constructions resulting from the inquiry contribute to the theoretical knowledge base of health visiting by explicating professional judgement and its relationship to needs assessment. The judgement process appears to incorporate a sophisticated process of needs assessment, influenced by a range of knowledge and experiences. Health visiting assessment is a complex, interactive and serial activity, with health visitors' co-ordinating information from several sources to assess health needs and formulate professional judgements. A key finding was the integration of some health visitor interventions with assessment processes.

Implications of the study findings for health visiting education, management and practice are critically examined and recommendations for future research are made.

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Introduction and Background to the Study

1.1 Introduction

The aim of the study is to examine health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support. The identification of children in need and the needs of their families is critically important in view of the recommendations of The Children Act (1989) and NHS Executive (1996). Since the introduction of the NHS and Community Care Act (1990) and The New NHS, Modern, Dependable (Dept. of Health, 1997) the issue of health needs assessment has become increasingly important in negotiations between commissioning agencies and provider organisations. Community nursing staff are expected to have well developed assessment skills in order to competently identify and articulate 'health needs', provide appropriate support services to clients and make relevant referrals to statutory and voluntary agencies (Twinn and Cowley, 1992). Since health visitors play such a valuable role in case finding it seems highly relevant to examine the nature of their professional assessments and use of practice guidelines in enhancing judgement processes. This chapter will provide an introduction to the study, it will outline why the topic was selected and how ideas for the research have developed.

1.2 The role of the health visitor

Since its inception in the middle of the nineteenth century, health visiting's roots have been firmly based in public health work (Cowley and Appleton, 2000). A health visitor is a registered nurse who has undertaken a further post-registration specialist practitioner qualification, focussing specifically on child and family health

promotion, public health issues and disease prevention. Yet recently, the extent to which the amalgamation of health visitor education with other branches of community nursing (UKCC, 1991) may have damaged the public health and child development specialist aspects of the role has been seriously questioned (Clark et al, 2000; Cowley et al, 2000a). Currently, the majority of health visitors work in the community within Primary Care Groups or Trusts and are employed by NHS Community Trusts or Health Boards. Central to the role is a focus on the identification and assessment of health need at both an individual and community level.

1.3 Assessing children and families in need

Despite attempts to move health visiting towards a community development focus, for the majority of health visitors work with mothers and pre-school children continues to be a priority (Bowns et al, 1998). All children under school age and their families are allocated to a health visiting caseload for purposes of health promotion and preventive care; with other groups being included depending on local policy. Health visitors are extremely well placed to identify children's needs and recognise parenting difficulties (Dept. of Health, 1999a). Assessment of family health and social need is a central feature of the health visitor's role in which a range of skills, knowledge and judgements are used. These assessments are crucial in identifying children and families in need and in determining levels of health intervention to be offered to families by the health visiting service. As Hendy (1983:199) has noted "*accurate assessment is always a necessary foundation on which to base professional judgement of need.*" As such the concept of assessment is implicit in the four principles of health visiting:

- The search for health needs
- The stimulation of the awareness of health needs
- The influence on policies affecting health
- The facilitation of health enhancing (CETHV, 1977).

Despite consensus by the profession that these principles remain extremely relevant to current practice (Twinn and Cowley, 1992), a key feature of the literature until very recently, is the limited amount of research investigating how health visitors identify

and make assessments of children and families with health needs. Indeed it was only in 1993 that Chalmers (1993:144) noted that no empirical evidence existed "*which provides clarification of how health visitors conceptualise needs and the actual practice strategies used to search out needs.*" This is surprising in view of the fact that since the implementation of the NHS and Community Care Act (1990) there has been considerable interest surrounding the impact of needs assessment on health promoting activities. Since then, it is interesting to note that most of the research in health visiting has tended to focus more generally on 'needs assessment' rather than a detailed examination of how health visitors identify and assess families needing extra support (This will be explored further in Chapter 2).

1.4 Working with children and families in need – Extra health visiting

In 1995 the Department of Health highlighted the potential for health professionals, particularly health visitors, to accurately identify and support 'children in need' and their families, and to protect vulnerable children. The refocusing debate that stemmed from the publication of Messages from Research emphasised the need to identify areas in which more interagency work can be undertaken preventatively with 'children in need' rather than 'children in need of protection' (Dept. of Health, 1995). Health visitors in particular were recognised as being in a unique position to identify families experiencing stress and to undertake short-term preventative work with families because of their current, albeit often limited, universal access to families (Dingwall, 1977; NSPCC, 1996; Appleton, 1996, Dept. of Health, 1999b). Recent Government policy has stressed the importance of supporting and promoting family life and well being (Home Office, 1998). Indeed the Independent Inquiry into Inequalities in Health Report (Dept. of Health, 1998a:124) recommends "*the further development of the role and capacity of health visitors to provide social and emotional support to expectant parents, and parents with young children.*"

The current policy context that acknowledges the central role which health visitors' play in supporting children and families in need is certainly exciting and deserves further examination. Within health visiting, the term 'vulnerable family' has

traditionally been used to describe families with additional health and social needs who require primary preventative input. Vulnerable families are identified in order that increased interventions and support services can be offered, in the hope that identified health needs can be met and child protection issues prevented. In health visiting the term 'vulnerable family' is often used interchangeably with 'high dependency', 'high intervention', 'cause for concern', 'high risk' or 'family/child(ren) in need' (Appleton, 1999). Yet as these terms suggest there is a lack consensus about the extent to which family vulnerability and child protection are linked.

Traditionally extra health visiting has centred on families where there are child protection concerns. Yet recent policy has attempted to distinguish between vulnerable children (those "*who would benefit from help from public agencies*" (Dept. of Health, 2000:2)), children in need (as defined in the Children Act (1989)) and children on the child protection register (where the child is suffering or is likely to suffer significant harm). Indeed the author has argued elsewhere for the need to recognise the existence of a 'child(ren) in need continuum' (Appleton and Clemerson, 1999).

1.5 Accessing children and families in need - Universal v. targeted service

Health visiting is currently facing considerable turmoil over the nature and existence of its role. There has been a long and continuing debate within the profession about the extent to which services generally and not only in terms of 'children in need', should be targeted at the level of the individual or the community. It is assumed that families who display no overt problems at a single contact (a first visit, used to assess needs) have no need for a health promoting service and therefore should not be visited on a routine or a regular basis (NHSE, 1996). Indeed this argument has been used to justify a dramatic reduction in health visiting services, which is illustrated in the decline in the number of whole time equivalent practising health visitors in England from 10,680 in 1988, 10,070 in 1998 to 8,067 in 1999 (HVA, 1994; Chamberlain Dunn Associates Ltd, 2000).

In contrast, those defending the maintenance of a universal home visiting service emphasise that it is often the most vulnerable and those not coping who are unable to seek help, and that programmes of selective visiting may fail to identify need adequately (Appleton, 1993; Smith, 1998; Robinson, 1999; Elkan et al. 2001). Furthermore the universal nature of the health visiting service may be important in helping clients to view it as non-stigmatising (Orr, 1980; Mayall and Foster, 1989) and socially acceptable (Machen, 1996).

In the United Kingdom 'children in need' identification is addressed through public health values and concepts, principally universal access to professionals through child health promotion programmes (Hall, 1996) which include the total population and ensure follow-up of families who do not initially take up the service. Targeted individual work with a child and family would only take place once a health need has been identified, yet this individual focus is not reached unless the whole population has access to child health promotion review services.

The Child Health Promotion Programme implemented by Health Authorities, Primary Care Groups/Trusts and Community Trusts ensures that regular contacts are offered to families with young children.[1] This provides the gateway to undertake both child and family health needs assessments and to offer increased levels of preventative intervention where necessary (Appleton and Clemerson, 1999). The review programme is extremely important because families may not easily be able to acknowledge or raise their worries, or make any connection between these concerns and their health status (Cowley and Appleton, 2000). Yet it is important to note that the review programme is implemented very differently across the country and that 'regular contacts' (not necessarily as many as suggested by Hall (1996)), are offered by a range of members of the primary health care team. In many areas only one health visitor contact is guaranteed. Ideally the Child Health Promotion Programme should enable health visitors to reach all children and identify those who, with their families, are potentially in need of advice, support and guidance, yet in reality this may not be a feasible prospect.

[1] In response to current health policy, Community Health Trusts are handing over primary care work including community nursing and child health work to Primary Care Trusts who will continue to implement the Child Health Promotion Programme.

1.6 Identifying children and families requiring extra health visiting support

Child health promotion work forms the basis for assessment and targeted work with children and families in need. However, it is important to note that health visitors have traditionally adopted a number of approaches to identify such children and families. Historically since the 1960s children and families requiring extra health visiting support have been linked with notions about family risk and potential for child abuse. This stems from a broadly medical and psychosocial approach to predicting child abuse.

1.6.1 Risk assessment

The identification of vulnerable families in the child protection/social work literature has been described by many authors as a form of screening, with risk assessment as a central feature. Risk assessment is "*the systematic collection of information to determine the degree to which a child is likely to be abused or neglected in the future*" (English and Pecora, 1994:452). This approach to assessing children and families has influenced a great deal of the early work in health visiting. It involves:

> *examining the child and family situation in order to identify and analyse various risk factors, family strengths, family resources, and available agency services. This assessment information can then be used to determine whether [or not] a child is safe.* (English and Pecora, 1994:453)

Risk assessment attempts to predict the likelihood of child maltreatment (Browne and Saqi, 1988; English and Pecora, 1994) through use of structured risk assessment instruments. However, the predictive value and ethical implications of such child abuse assessment instruments have been seriously questioned (Gibbons, 1988; Barker, 1990; Douek, 1995; Browne, 1995; Crompton et al, 1998; Goddard et al, 1999). Criticisms centre on the fact that the predictability of risk assessment instruments is not sufficiently high for them to be regarded as reliable tools. Most contain risk factors frequently found in many groups across the population, yet serious incidents of child maltreatment often involve unpredictable circumstances (Cleaver et al, 1998a). Elkan et al. (2001:117) have criticised such guidelines for failing to acknowledge

"*a continuum of risk*", their limited predictive outcomes and that risks and needs change over time so rendering the one off assessment devoid of use.

Despite such criticisms, 'risk assessment' has been widely adopted in health visiting as an approach to assessing children and families in need. A review of the literature (Appleton, 1994a) found that the majority of studies (by both health visitors and non-health visitors) have attempted to identify vulnerable families by using standardised checklists or other screening tools which are extremely dubious in their validity (Gray et al, 1977; Dean et al, 1978; Waterhouse, 1981; Ounstead et al, 1982; Monaghan and Gilmore, 1986; Browne, 1989; Walker and Crapper, 1995). Overall the research has taken a somewhat mechanistic approach; by focussing on screening tools, the value of professional judgement in the assessment process has largely been ignored. Certainly, the continued adoption of this approach to identifying family vulnerability, despite the lack of a substantial research base to support its use, points to the fact that the idea of 'the checklist' is firmly rooted in the management and practice of health visiting.

1.6.2 Clinical practice guidelines

With the introduction of the internal market in the 1990's, there was an impetus to develop clinical guidelines to identify 'vulnerable' families and introduce visiting protocols which prescribe the numbers of contacts which health visitors should be making with families with pre-school children (Carney et al, 1996). However, these policy initiatives continue to demonstrate a lack of understanding about the complexity of health visitors' preventative work and the activity of needs assessment. It is likely that the 'Framework' recently outlined by the Department of Health (2000) for assessing children in need and their families will inform future practice guidance. 'The Framework for the Assessment of Children in Need and their Families' offers a core foundation for a systematic approach to assessing children and families' needs, while emphasising the need to safeguard and promote children's welfare. It incorporates three key areas :-

- *the developmental needs of children*
- *the capacity of parents/caregivers to respond appropriately to those needs*
- *the impact of wider family and environmental factors on parenting capacity and the child (Dept. of Health, 2000:17).*

Attempts to identify health and social need using caseload weighting approaches to determine staffing levels are also popular in health visiting. In order to link caseload weighting with families' need for health visiting, practitioners are required to gather information from clients by assessing the presence of specified health and social factors. Yet as Horrocks et al.(1998) found this approach is not without problems. These researchers attempted to determine the reliability and validity of a caseload weighting system by examining health visitors' interpretation of 28 health and social factors. The findings suggest that there was little agreement about how these factors could be used to organise work across a group of health visitors. There were some quite marked variations in interpretations of the particular meanings of factors and the threshold for assigning a factor to a family. Many of the health and social factors that related to child protection were rated as highly significant by participants, with the majority of health visitors regarding child protection work as their highest priority. Horrocks et al. (1998:343) conclude that:

> *health visitors' prioritisation of child protection, and child protection related health and social factors, raised the possibility that caseload weighting might be used as a 'child protection checklist' rather than an overall measure of health visitor need.*

This outcome highlights once again the perceived link between family vulnerability and child protection.

1.6.3 Professional judgement

A third approach to assessing the needs of children and families is indicated by Wheeler's (1989; 1992) study and my earlier MSc research work (Appleton, 1993) which found health visitors relying on professional judgement when making family assessments. In the latter study it was interesting that despite criteria being available in the study sites to assist health visitors in the identification of vulnerable families, a critical finding of the research was that a large proportion of respondents were using their own professional judgements in the assessment of families' needs. This certainly contrasts with the previous literature and Browne's (1995:59) assumption that "*health visitors commonly use checklists of risk factors both officially and unofficially.*"

Chalmers (1993) in a grounded theory study explored the processes involved in how health visitors search out and stimulate clients' awareness of health needs. Through interviews with forty-five experienced health visitors she found that a complex range of processes were used to identify clients' needs. Chalmers (1993:160) found that health visitors offered clients different levels of input depending on two factors: the practitioner's assessment of clients' "*worthiness for* [the] *service*" and secondly, how clients responded to the health visitors offers of support. For example, clients responding in a positive manner were more likely to receive extra input from the health visitors. An interesting feature of the study was that these health visitors appeared to be functioning according to their own practice agendas (Chalmers, 1993).

The results of these three studies suggest that individual health visitor professional judgement may have a significant role to play in the identification of children and families requiring extra health visiting support. Indeed in summarising the results of a systematic review of the effectiveness of domiciliary home visiting Elkan et al. (2000:249) state "*the professional judgements of health visitors are crucial to an assessment of the need for services*". Therefore it seems that the concept of professional judgement certainly warrants further investigation.

1.7 So where next?

Current government policy clearly highlights health visitors' crucial role in working with children and families in need. Furthermore personal experience suggests that many health visitors spend much of their time working with families, supporting and empowering parents to help them to cope with the stresses of parenting and other life events. In light of these factors and the findings of the earlier MSc work, it seems highly relevant to explore health visitors' professional judgements and use of formal guidelines for identifying families requiring extra health visiting support. This chapter has briefly outlined the particular methods and approaches used by health visitors to identify children and families requiring extra health visiting. These include risk assessment screening, the use of guidelines, such as caseload weighting and health visitor professional judgement. Two issues appear important and emerge from this brief introduction. Firstly, the extent to which assessment guidelines and visiting

protocols direct health visitors in making assessments of family health needs. Secondly, the nature and value of health visitors' own professional judgements and factors that influence those judgements.

In view of the potential importance of health visitor professional judgement in the assessment of family health need, Chapter 2 will explore the concept of professional judgement in contemporary health visiting in greater detail, utilising Morse's (1995) method of advanced concept analysis. Chapter 3 will then report on a national study undertaken to evaluate the clinical practice guidelines in existence in Community Trusts to assist health visitors in identifying families requiring extra health visiting support. This chapter will describe the documentary analysis method used in this preliminary research work and present the key findings that provided the groundwork for the main study.

The aims and objectives of the main study are outlined in Chapter 4. This chapter also offers an exploration of the philosophical underpinnings of the main study through an analytical discussion of the constructivist research paradigm. The suitability of this philosophical approach for the detailed examination of health visiting practice is explored.

Chapter 5 describes how a case study strategy guided by a constructivist methodology was utilised to facilitate the integration of multiple sources of data. The chapter outlines a framework for constructivist investigation developed specifically for nursing research from the original work of Lincoln and Guba (1985). This framework is used to detail the steps of this research methodology and explicate the researcher's decision making in examining the concept of professional judgement.

Findings chapters explore a range of issues, initially describing in Chapter 6 health visitors' perceptions about the adequacy of local guidelines for identifying family health need across the three case study sites. Chapter 7 examines health visitors' constructions of professional judgement, while Chapters 8 and 9 attempt to explicate the various elements associated with the processes of identifying and assessing family health needs. The analysis suggests that the health visiting assessment process is a

complex, interactive and serial activity, with health visitors' co-ordinating information from a variety of sources in order to assess health needs and formulate professional judgements. Finally Chapter 10 returns to the notion of 'extra health visiting support', exploring this concept from both the health visitors' and clients' perspectives.

In the final chapter the key findings of the thesis are summarised and the extent to which the initial study objectives have been achieved are discussed. The implications of the study findings for health visiting education, management and practice are critically examined using the principles of health visiting (CETHV, 1977) as a framework for discussion. Finally the study's limitations are considered and recommendations for future health visiting research are made.

To conclude, this thesis takes a step forward in clarifying health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support.

Chapter 2

The Concept of Professional Judgement

2.1 Introduction

This chapter will examine the concept of professional judgement in contemporary health visiting practice utilising a method of advanced analysis advocated by Morse (1995). It will consider definitions of professional judgement and review the relationship between this concept and those of clinical reasoning, clinical judgement and decision making. It will attempt to explicate the differences and commonalties between these concepts that are often used interchangeably in the literature. The chapter will also explore the nature of professional knowledge and outline conceptual frameworks used in the study of judgement and decision making. An extensive body of theoretical and empirical literature exists in this area, particularly in relation to acute hospital medical and nursing care. However, although the health visiting literature has many references to the term professional judgement there is little evidence of the topic having received a detailed analysis. Indeed there appears to be a paucity of health visiting research in this area. In view of this, an attempt has been made to critically review all research examining judgement and decision making in the wider field of community nursing. Finally a justification is made for pursuing research into professional judgement in health visiting.

2.2 Professional judgement in health care

Professional judgement is an integral part of effective health care delivery. Recent legislation has stressed the need for qualified health care practitioners to have the skills and knowledge to make sound professional judgements (Dept. of Health, 1997; Dept. of Health, 1999a). In an interview on the BBC Today Programme on Radio 4, Frank Dobson, then Secretary of State for Health stressed the importance of

professional autonomy, and that nurses and doctors, in deciding if a patient needs treatment or care "*should be using their clinical judgement, it's up to them*" (Dobson, 1998). This level of autonomy is a recognised and accepted part of professional health care practice and such professional status assumes "*the ownership of a specific body of knowledge which informs practice*" (Luker and Kenrick, 1992:458). There is also an expectation that all newly qualified health care professionals will have achieved a certain level of skill in professional judgement and decision making (Dept. of Health, 1999a; UKCC, 1999).

The recent emphasis on the provision of high quality and accountable health services through clinical governance, incorporating strategies to promote clinical effectiveness and evidence based health care has also done much to highlight the importance of professional experience. In 'A First Class Service' issues around clinical decision making were brought to the fore, when the Secretary of State for Health wrote "*clinical decisions should be based on the best possible evidence of effectiveness, and all staff should be up to date with the latest developments in the field*" (Dept. of Health, 1998b). Evidence based health care, defined as the "*integration of individual clinical expertise with the best available external evidence from systematic research*" (Sackett et al, 1997:2), again emphasises the importance of professional experience and sound professional judgement.

Despite the central role which professional judgement plays in health care professionals' work, Fish and Coles (1998) note that much of this work is undertaken intuitively and that professionals often have difficulty explaining their clinical practice knowledge base. They argue that many health professionals cannot articulate "*the basis of their professionalism*" (Fish and Coles, 1998:9) because of the way that they have been educated and the lack of available opportunities to examine the nature of professional expertise and knowledge in clinical practice. Like Eraut (1994), these authors state that professionalism is also being eroded by many factors including increasing public distrust of 'professional status', professional isolation, a commissioning ethos which requires contracts with clearly defined outcomes, an increase in litigation and politicians who increasingly seek to regulate and control health professionals' work.

Fish and Coles (1998) argue cogently that there is a real need to examine the foundation of professional practice and to adopt a view of practice that promotes 'professional artistry'. Twinn (1989; 2000) also supports this view through her research into the education of health visitor students. Professional artistry emphasises the professional's moral, ethical and practical responsibilities and "*recognises that the quality of health care rests on the appropriateness of the judgement made*" (Fish and Coles, 1998:42). Central to this view of professionalism is the fact that professional knowledge emerges from practice experiences through a process of critical reflection, building on formal knowledge (sometimes referred to as "*scientific*" (Rolfe, 1998a; 1998b) or "*public knowledge*" (Eraut, 1994:17)) to become personal knowledge (Eraut, 1994; Fish and Coles, 1998). A commitment to lifelong learning and continuing professional development are recognised as crucially important in assisting health professionals to develop professional knowledge as a basis for making sound judgements (Orme and Maggs, 1993; Higgs and Jones, 1995a).

2.3 Professional judgement in health visiting

In the course of professional practice, health visitors are continually expected to make professional judgements and engage in complex decision making. Health visitors are autonomous practitioners, who accept responsibility for and are accountable for their professional actions (UKCC, 1992). They need to be able to justify judgements and decisions made. It therefore follows that health visitors need to practise from a sound knowledge base, but also recognise that this knowledge base is continually developing. Health care practice is subject to relentless policy change, the context of care is complex and uncertain, and it is imperative that health visitors can respond effectively to these demands. In order to do this health visitors must understand the judgement process, they need to know how to make sound professional judgements to ensure effective healthcare delivery for clients and the appropriate use of resources (Orme and Maggs, 1993). Health visitors also need to be aware of their own fallibility in making judgements (Wurzbach, 1991) and have the personal insight to limit errors in judgement. In order to develop health visiting professional practice, there is a clear need to examine the area of professional judgement in more detail in order to develop

a clearer understanding about the basis of professional action. As an initial starting point it was deemed desirable to undertake a more detailed analysis of the concept of professional judgement in an attempt to clarify its meaning and gain a better understanding of this important concept.

2.4 Concept analysis

Concepts are widely used in theory development and form the basic building blocks from which theories are constructed (Hardy, 1974; King, 1987). Chinn and Kramer (1999:54) define a concept as "*a complex mental formulation of experience.*" Concept development is a critical, analytical and reflective process. Creating conceptual meaning is a way of conveying "*thoughts, feelings and ideas that reflect the human experience of the concept*" and offers a basis for developing theory (Chinn and Kramer, 1999:54).

In order to continue to develop the body of health visiting knowledge, it is essential that researchers precisely define the attributes and meanings of concepts as these provide the basis for theoretical clarification and operational definitions for practice and research (Kemp, 1985:383). One tool to use is the process of concept analysis, described by Walker and Avant (1983:35) as "*a formal linguistic exercise to determine" the key "attributes or characteristics of a concept.*" It is a strategy to facilitate critical thinking (Kemp, 1985), a rigorous and individual exercise which enables researchers/practitioners to develop valid arguments to clarify a concept's purpose and dimensions for use in practice and research.

Several authors have proposed methods of concept analysis, for example Wilson (1969), Walker and Avant (1983) who further developed Wilson's method, Rodgers (1989) and Chinn and Kramer (1999). Rodgers' (1989) criticisms of Walker and Avant's (1983) framework for concept analysis stem from its reductionist and static approach and failure to acknowledge the interrelationships which may exist between concepts in real life. Instead Rodgers (1989) proposed an 'evolutionary view' for concept analysis using raw data and ensuring consideration of context throughout the process of concept analysis.

More recently Morse (1995) has offered a further description of concept analysis techniques. She too criticises the original Wilson (1969) method for producing "*trivial and insignificant results*" and characteristics "*devoid of context so that the practical application is lost, and the results are often so obvious that the analytical efforts do not even advance nursing knowledge*" (Morse, 1995:32).

She is equally sceptical about Rodgers' (1989) approach still concluding with a 'model case', which she regards as a "*hypothetical ideal*" (Morse, 1995:32) arguing that the analysis is limited to a single situation (Morse et al, 1996). Instead Morse (1995) recommends using qualitative data or a critical analysis of the literature to clarify and refine concepts. She acknowledges that the attributes of concepts may manifest themselves "*in different forms according to the context in which the concept is used*" but still be part of the same conceptual category (Morse, 1995:35). Morse (1995:36) also recognises that in some cases concepts may be used interchangeably in the literature, she thus suggests a process of "*concept comparison*" to examine the differences between such similar concepts. Thus an adaptation of this process has been used to examine the concept of professional judgement and to distinguish its parameters from those of clinical judgement, clinical reasoning and decision making.

2.5 The purpose of the analysis

The development of sound professional judgement is continually advocated in health care practice, yet there is a general lack of clarity around this concept. This is emphasised by Eraut (1985:125; 1994:49) who regards professional judgement as a "*mysterious quality*". Indeed rather than providing a consistent definition, the literature reveals that the concept of professional judgement is often used interchangeably with the terms clinical judgement, clinical reasoning and decision making (Alfaro-Le Fevre, 1996). These terms appear frequently in both the empirical and theoretical literature, yet confusion surrounding terminology arises from the fact that many authors fail to clearly define the exact meaning of these concepts (e.g. Hepworth, 1989). Furthermore, the differences between these concepts are not clearly explicated and there is limited evidence about the relationship between them. To add further confusion the phrase 'professional judgement' is often presented in such

a way that assumes an automatic understanding of this concept on the part of the reader (e.g. Fish and Coles, 1998). Thus the focus of this analysis is to clarify the meaning of professional judgement in order to gain a clearer understanding of this concept.

2.6 The scope of the literature reviewed

A number of computer databases and bibliographies have been accessed, combined with manual search techniques and utilised in the systematic search for and review of relevant material. For more details on the literature search and the range of search terms used please refer to Appendix 2.1. The results suggest that an extensive body of theoretical and empirical literature exists in this area, particularly in relation to acute hospital medical and nursing care. However, although the health visiting literature has many references to the term professional judgement there is little evidence of the topic having received a detailed theoretical or empirical analysis.

2.7 Use of the concept

This section will explore the essential nature of professional judgement and examine existing definitions of the concept. Although this analysis will concentrate primarily on 'professional judgement', the term judgement is used widely in health care and other disciplines. It seems pertinent to initially outline the various meanings and usages of this term in its broader context. Interestingly the Collins English Dictionary (1998:833) defines the term judgement in a number of different ways:

- *the faculty of being able to make critical distinctions and achieve a balanced viewpoint*
- - *the verdict pronounced by a court of law*
  - *an obligation arising as a result of such a verdict*
  - *the document recording such a verdict*
- *the formal decision of one or more judges at a contest or competition*
- *a particular decision or opinion formed in a case of dispute or doubt*
- *an estimation*
- *criticism or censure*
- *the estimate by God of the ultimate worthiness or unworthiness of the individual or of all mankind*
- *God's subsequent decision determining the final destinies of all individuals.*

These various meanings indicate the complexity of the topic area and highlight the usage of the term judgement not only in everyday language but also in the legal and religious arenas. Some meanings also reflect the close relationship between the term judgement and the formation of an opinion or decision in cases of doubt. Abercrombie (1969:14) supports this view and states that judgement is a process that involves "*making a decision or conclusion on the basis of indications and probabilities when the facts are not clearly ascertained.*" She argues that individuals are continually selecting from available information, interpreting this data with information acquired previously and making future predictions (Abercrombie, 1969). Dancy and Sosa (1993:228) have attempted to unpack the various elements of judgement and state that the term "*may refer to a faculty (of judgement), an act (of judging), or the product of an act (what is judged).*" These authors go on to say that however derived, judgements may be either spontaneous or the product of practical or theoretical consideration (Dancy and Sosa, 1993). In nursing assessment Crow et al. (1995:209) define a judgement as a "*statement which expresses the nurse's estimate of someone's condition or situation*"

2.8 Professional judgement – Definitions

When combined with the term 'professional', it is indicative that a judgement is made by "*a person who belongs to or engages in one of the professions*" (Collins English Dictionary, 1998:1233). According to Eraut (1994:49) professional judgement "*involves practical wisdom, a sense of purpose, appropriateness and feasibility; and its acquisition depends, among other things, on a wealth of experience.*" He states that this sort of practical wisdom incorporates two dimensions, firstly "*a sufficient range of experience to ensure a balanced perspective*" and secondly "*an intuitive capacity to digest and distil previous experience and to select from it those ideas or procedures that seem fitting or appropriate*" (Eraut, 1994:49). Rolfe (1998a; 1998b:15) regards professional judgement as a problem-solving process and equates this to a combination of "*personal knowledge*" of patients and "*previous clinical experience.*" He argues that little thought has been given to explicating the true nature of professional judgement in nursing (Rolfe, 1989b) and the dearth of literature indicates that the same can be argued for health visiting.

Table 2.1: Constructs embedded in definitions of professional and clinical judgement, clinical reasoning and decision making.

Constructs	Erauf (1994)	Rolfe (1998)	McMurray (1989)	Dreyfus and Dreyfus (1986)	Brykczynski (1989)	Tanner (1986, 1987)	Baumann and Deber (1989)	Del Bueno (1990)	Henderson (1987)	Polge (1985)	Benner et al. (1996)	Higgs and Jones (1995)	Barrows and Feltovich (1987)	Rivett and Higgs (1995)	O'Sullivan (1999)	Baumann and Deber (1989)	Maclean (1989)
An understanding of pt/client problems or state											✓						✓
Involves practical wisdom	✓		✓	✓	✓							✓			✓		
A sense of purpose	✓										✓						
Acquired through a range of experience	✓	✓								✓				✓			
Intuitive capacity to digest/distil previous experience	✓		✓	✓							✓			✓	✓		
Selection of appropriate ideas/procedures/ actions from previous experience	✓																
Problem solving process		✓										✓	✓				
Acquired through previous clinical experience		✓												✓			
Acquired through personal knowledge of patients		✓															
Careful analysis			✓												✓		
Reflects a clinical knowledge base					✓					✓		✓		✓			
A complex process						✓	✓	✓				✓					✓
Involves making a series of decisions						✓											
Equated with nursing diagnoses			✓						✓								
Applied in acute care settings					✓	✓		✓		✓	✓						
Skill in critical thinking										✓		✓					
Advanced stages of cognitive development								✓		✓		✓					
Attend to and respond to salient information											✓	✓					
Involves decision making processes											✓	✓			✓		
Holistic discrimination / a sense of whole								✓			✓	✓					✓
Conscious deliberation / structures meaning from mass of data												✓			✓		
Incorporates professional judgement (professional intuition)														✓			
Making a choice from number of alternatives															✓	✓	✓
Decision making process and outcome															✓		

■ Professional Judgement ☑ Clinical Judgement ✓ Clinical Reasoning ✓ Decision Making

In view of the apparent interrelated nature of the concepts of professional judgement, clinical judgement, clinical reasoning and decision making it is important to consider individual definitions and attempt to elucidate their specific components (See Table 2.1).

2.9 Competing concepts

2.9.1 Clinical judgement – Definitions

McMurray (1989:40) building on the work of Dreyfus and Dreyfus (1986) describes clinical judgement as deriving "*from a blend of intuition, careful analysis and the wisdom and judgement distilled over time.*" Reinforcing this emphasis on wise thinking, Brykczynski (1989:76) states that it "*is the essence of practical wisdom. It is the least specifiable, yet most crucial, aspect of clinical knowledge*". Indeed Benner et al.(1996:2) describe clinical judgement as

> *the ways in which nurses come to understand the problems, issues, or concerns of clients/patients, to attend to salient information, and to respond in concerned and involved ways; [it includes] both the deliberate, conscious decision-making characteristic of competent performance and the holistic discrimination and intuitive response typical of proficient and expert performance.*

The complexity of the judgement process and its importance are well documented in the literature (Tanner, 1986; Baumann and Deber, 1989; Del Bueno, 1990). Furthermore Tanner (1986) has suggested that clinical judgement involves making not one, but a series of decisions including decisions about what to observe, what data suggest, what actions to take and she describes clinical judgement as "*a dynamic*" and "*interactive process*" (Tanner, 1986:35). The literature reveals that nurses and doctors working in acute care settings frequently adopt the term clinical judgement when describing judgement processes. Some authors equate clinical nursing judgements with nursing diagnoses (Henderson, 1978; McMurray, 1989). While Polge (1995:4) has outlined four components which are essential for making sound clinical judgements:

- *skill in critical thinking*
- *a relevant knowledge base*
- *a relevant experience base for application to the clinical situation*
- *advanced stages of cognitive development.*

2.9.2 Clinical reasoning - Definitions

Higgs and Jones (1995a:xiv) regard clinical reasoning as a broad term, which they define "*as the thinking and decision making processes which are integral to clinical practice.*" It is a complex phenomenon which involves "*attempting to structure meaning from a mass of confusing data and experiences occurring within a specific clinical context and then making decisions based on this understanding*" (Higgs and Jones, 1995b:3). They contend that clinical reasoning incorporates three core elements:

- the use of knowledge specific to the discipline
- the effective utilisation of cognitive or thinking skills (including data collection, analysis, synthesis and evaluation)
- metacognition, a "*higher order cognitive skill*" concerned with "*the awareness and monitoring*" of thinking processes (Higgs and Jones, 1995b:3).

They argue that clinical reasoning enables a professional to adopt "*'wise' action*" in other words "*taking the best judged action*" in a particular clinical situation (Higgs and Jones, 1995b:3).

The clinical reasoning process is often associated with, or referred to as, the problem solving process (Barrows and Feltovich, 1987; Higgs and Jones, 1995a). While Rivett and Higgs (1995:16) state that clinical reasoning encompasses;

> *personal and professional craft knowledge and professional judgement (sometimes referred to as "professional intuition") gained through experience and reflection on experience.*

2.9.3 Decision making – Definitions

The Collins English Dictionary (1998:408) defines a decision as

- *a judgement, conclusion or resolution reached or given*
- *the act of making up one's mind.*

O'Sullivan (1999:10) states that decision making is "*the process of making a choice, where the emphasis is on making, that is constructing, a choice*" from a number of possible alternatives (Baumann and Deber, 1989; MacLean, 1989). Making this choice can involve either a process of conscious deliberation or a choice can be made intuitively without resolve to conscious deliberation or thinking (O'Sullivan, 1999). Sound decision making concerns both process and outcome (O'Sullivan, 1999). Many authors have highlighted the complex nature of the decision making process because of the diversity of variables involved (MacLean, 1989). MacLean (1989:75) argues that rational decision making incorporates two main elements, firstly "*the ability to reason logically to derive inferences about the patient state and* [secondly] *to choose from among a set of alternative actions.*"

2.9.4 The relationship between professional judgement, clinical judgement, clinical reasoning and decision making

From the above definitions and embedded constructs highlighted in Table 2.1, it would appear that the concepts of clinical judgement and professional judgement constitute very similar meanings. The former is applied mainly in acute care settings and the latter more acceptable for use in health visiting, with its non-clinical emphasis. Morse's (1995) framework for concept analysis readily acknowledges that two concepts belonging to the same conceptual category, in this case 'judgement', may have common attributes while being derived from different contexts. A consistent theme of the judgement and clinical reasoning definitions is the emphasis on 'wise judgement' with the professional drawing on relevant past experiences, intuitively distilling pertinent data and balancing or making an estimate of the evidence presented. Indeed clinical reasoning can be regarded as an umbrella term encompassing all elements of judgement and decision making processes. (See Figure 2.1).

The literature indicates that decision making involves an element of choice and selection. Indeed cognitive psychologists would argue that judgement provides a guide for making a decision, "*which leads to a choice, which then produces an outcome*" (Rachlin, 1989:43). Rachlin (1989) and Carroll and Johnson (1990)

Figure 2.1: The clinical reasoning process

maintain that when an individual makes a decision this always involves judgement, which can either be at a conscious or unconscious level. Judgements guide behaviour and are part of the decision making process, however "*unlike a decision, a judgement is never the end of a process*" (Rachlin, 1989:43). This latter view is supported by Bryans and McIntosh (1996) and O'Sullivan (1999) who regard judgement as one stage in the decision making process.

On the whole though the nursing literature provides little clarity about the use of the terms judgement, reasoning and decision making and the relationship between these concepts is often contradictory and largely ignored. Although generally speaking the decision making process is often considered equivalent to the clinical reasoning process, it is perhaps more useful to restrict the definition of a decision making process to one that produces an outcome based on multiple inputs, some of which may actually be judgements. The above definitions imply that a clinical reasoning model might incorporate multiple decision making processes in addition to judgement

determinations. Furthermore, it is interesting to note that an attempt to discover the client perspective is notable for its absence in the above definitions.

Table 2.2: A comparative delineation of the attributes of professional and clinical judgement, clinical reasoning and decision making.

Attribute	Professional Judgement	Clinical Judgement	Clinical Reasoning	Decision Making
The process by which a professional detects, assesses and interprets external information and internal stimuli by means of the sensory receptors (or received via the senses).	✓	✓	✓	
Incorporates practical wisdom - the process of being able to think and act utilising a combination of propositional and non-propositional knowledge, experience, understanding, consideration of moral issues, common sense and insight.	✓	✓	✓	
A capacity to intuitively synthesise and distil previous clinical and life experiences and professional knowledge to structure meaning and reach an understanding of something. This may be immediate or take place over a period of time.	✓	✓	✓	
Estimating the significance of a variety of evidence.	✓	✓	✓	✓
Results from exposure to a clinical situation, event or incident.		✓	✓	
The process of making a decision based on an understanding of something.			✓	✓
It involves an analysis and consideration of two or more choices/options and the ability to reason logically and explicitly about these choices.			✓	✓
The process of making the choice.			✓	✓
Incorporates judgement which might be derived consciously or subconsciously.			✓	✓

2.10 Defining attributes

See Table 2.2 for a delineation of the attributes of professional judgement compared with the competing concepts of clinical judgement, clinical reasoning and decision making.

The above definitions and review of the literature provide a foundation for identifying the attributes of professional judgement. These are:

- The process, by which a professional detects, assesses and interprets external information and internal stimuli by means of the sensory receptors (or received via the senses).
- Incorporates practical wisdom – the process of being able to think and act utilising a combination of propositional and non-propositional knowledge, experience, understanding, consideration of moral issues, common sense and insight.
- A capacity to intuitively synthesise and distil previous clinical and life experiences and professional knowledge to structure meaning and reach an understanding of something. This may be immediate or take place over a period of time.
- It involves estimating the significance of a variety of evidence.

2.11 Review of the literature

The following literature review is divided into three sections in an attempt to present an analytical overview of the three relevant themes. The literature is used as a data source in an attempt to compare and contrast attributes and to further delineate between professional judgement and the competing concepts of clinical judgement, clinical reasoning and decision making. The results suggest that an extensive body of theoretical and empirical literature exists in this area, particularly in relation to acute hospital medical and nursing care. The first section will explore knowledge as a basis for professional judgement and decision making while the second section will examine the conceptual frameworks used in the study of judgement and decision making. The final section will review the pertinent research literature in health visiting and community nursing. In view of the dearth of health visiting research on professional judgement, an attempt has been made to critically review all research examining judgement and decision making in the wider field of community nursing.

2.12 Knowledge and its relationship to professional judgement

Knowledge is the basis for making effective health care judgements and decisions and a comprehensive knowledge base for practice will be "*derived from many sources*" (Wilson-Barnett and Batehup, 1988:1). Any group of individuals claiming professional status must have a knowledge base which is unique to the discipline and which legitimises their professional role (Behi and Nolan, 1995; Higgs and Titchen, 1995), indeed it can be regarded as a central antecedent to professional judgement. As such it is important to examine the types of knowledge and ways of knowing which are likely to influence health visiting practice. However, it is worth pointing out that while nursing knowledge has been examined by many nurse theorists and researchers; with the exception of Robinson (1982) and Goding and Cain (1999), few attempts have been made to explore the nature of health visiting knowledge per se. As such in an attempt to highlight the main features of the professional knowledge literature, this section will draw on key nursing and educational literature.

In her seminal paper on ways of knowing in nursing Carper (1978), drawing on the earlier works of Dewey (1958) and Polanyi (1962) outlined four approaches to knowledge adopted in nursing practice, these are empirics, ethics, aesthetics and personal knowledge. Empirics concerns the scientific body of nursing knowledge and its purpose is to describe, explain and predict phenomena. Ethics is concerned with moral knowledge, making judgements about what is right and wrong. Aesthetics, sometimes known as the art of nursing, describes "*the knowledge gained by subjective acquaintance, the direct feeling of experience*" (Carper, 1978:16). Personal knowledge is about knowing one's self and is regarded as the most difficult to learn. Since the publication of this paper there has been a wealth of literature, mainly theoretical in focus and generally relating to nursing in hospital settings which has examined Carper's ways of knowing (e.g. Ingram, 1994; Johns, 1995). Indeed White (1995) in a critique of Carper's ways of knowing recommended the addition of a fifth pattern 'socio-political knowing' which reflects "*the socio-political context of the ... nurse and patient*" (White, 1995:84) and the broader health care context. Clearly this type of knowing is highly relevant to heath visiting with its public health agenda. White argues that this way of knowing should encourage "*nurses to question the*

taken-for-granted assumptions about practice, the profession and health policies" (White, 1995:83-84) and engage in health policy debate.

There have been many attempts to describe the different aspects of professional knowledge. As Bryans (1998:39) succinctly states "*the field of professional knowledge resembles a conceptual maze*" and stems in part from the complex nature of knowledge and an incomplete understanding of how professional knowledge is acquired, developed and utilised. In all fields of nursing there is currently an emphasis on the need to explicate knowledge for practice through the use of reflection (Rolfe, 1998b). Knowledge is also created by practitioners' own search for meanings, through research and through professional practice, it is "*a dynamic phenomenon undergoing constant change and testing*" (Higgs and Titchen, 1995:130). Eraut (1994:15) has highlighted the increasing recognition that "*important aspects of professional competence and expertise*" cannot be publicly accessed and explained purely as propositional knowledge. He differentiates between the public knowledge base of a profession (training courses and professional publications) and the individual professional's 'personal knowledge' which is embedded in their actions and informs their professional judgement (Eraut, 1994).

Eraut (1994:16) has suggested that the whole 'domain' of knowledge consists of many different forms, including "*procedural knowledge, propositional knowledge, practical knowledge, tacit knowledge, skills and know-how.*" Indeed confusion can arise from the fact that some of these terms are used interchangeably and categorisations of knowledge types vary (See Table 2.3). For example, some authors differentiate between practical knowledge and experiential knowledge (e.g. Heron, 1981; Burnard, 1987), whereas others do not.

2.12.1 Propositional knowledge

The literature indicates that most consensus surrounds propositional knowledge which is regarded as theoretical or "*textbook knowledge*" (Burnard, 1987:190). It can be developed in any research paradigm and is largely constructed through the work of

Table 2.3: Categorisations of knowledge types

Categories of knowledge	Polanyi (1962)	Ryle (1963)	Carper (1978)	Heron (1981)	Burnard (1987)	Higgs and Titchen (1995)	Eraut (1985)	Rolfe (1998)	Schon (1983, 1987)	Kolb (1984)
Tacit knowledge (Personal knowledge)	✓						✓			
Knowing that (Propositional knowledge - textbook knowledge)		✓								
Knowing how (Non-propositional knowledge)		✓					✓			
Empirical knowing (Scientific knowledge)			✓							
Ethics (Moral Knowledge)			✓							
Aesthetics (Direct experience)			✓							
Personal Knowledge (Knowing oneself and an accumulation of subjective life experiences)			✓			✓				✓
Propositional knowledge (Theoretical knowledge, truths and facts)				✓		✓				
Practical knowledge (Skills, knowing how to so something)				✓	✓					
Experiential knowledge (Knowledge through direct personal encounter/experience)				✓	✓					✓
Propositional knowledge (Textbook knowledge - 'Knowing that')					✓	✓	✓			✓
Propositional knowledge (Generated through research)						✓				✓
Technical rationality (Scientific knowledge)									✓	
Knowing-in-action (Professional artistry)									✓	
Professional craft knowledge (Knowing how to do something and tacit knowledge)						✓				
Skills (Practical know how)							✓			
Procedural knowledge (Know that - propositional knowledge)							✓			
Practical knowledge (Practical know how)							✓			
Scientific knowledge (textbook knowledge) - **theoretical** (Knowing that)**or practical** (Knowing how)								✓		
Experiential knowledge (Clusters of processed experiences) - **theoretical** (Knowing that) **or practical** (Knowing how)								✓		
Personal knowledge (knowledge of unique individual clinical situations; processed experience) - **theoretical** (Knowing that) **or practical** (Knowing how)								✓		
Social knowledge (Accumulation of prior cultural experience)										✓

researchers and theorists. Eraut (1994:103) states that propositional knowledge is made up of:

- *discipline-based theories and concepts, derived from bodies of coherent, systematic knowledge*
- *generalisations and practical principles in the applied field of professional action*
- *specific propositions about particular cases, discussions and actions.*

This view of knowledge equates to Carper's (1978) use of the term 'empirics' and is regarded as the easiest form of knowledge to articulate. Propositional knowledge is often compared to the philosopher Ryle's (1949) description of 'knowing that' (Benner, 1984; Burnard, 1987). This term has been examined by philosophers in some detail and Hospers (1990:20-21) suggests that there are three standard requirements for 'knowing that':

- *the statement must be true*
- *you must believe the statement is true*
- *there must be good evidence for believing the statement.*

2.12.2 Non-propositional knowledge

Propositional knowledge is frequently explained and contrasted with a body of non-propositional knowledge (Higgs and Titchen, 1995). Non-propositional knowledge is used as an umbrella term to describe the following different types of knowledge:

- practical knowledge (sometimes known as process knowledge)
- intuitive/tacit knowledge
- personal knowledge
- experiential knowledge.

Higgs and Titchen (1995:138) argue that non-propositional knowledge guides nursing interventions and "*underpins the practitioner's rapid or fluent response to a situation.*"

Practical knowledge

Practical knowledge corresponds to practical skills and expertise, which Benner (1984:2) states can be "*acquired without 'knowing that'*". Practical knowledge is

demonstrated through skill mastery, though not necessarily psychomotor skills (Burnard, 1987) and equates to Ryle's (1949) view of 'knowing how'. This conceptualisation is developed further by Schön (1983; 1987) who makes a clear distinction between technical rational professional knowledge and 'knowing in action' or professional artistry.

Schön (1983:54) defines knowing in action as the:

> *actions, recognitions, and judgements which we know how to carry out spontaneously; we do not have to think about them prior to or during their performance. We are often unaware of having learned how to do these things; we simply find ourselves doing them. In some cases, we were once aware of the understandings which were subsequently internalised in our feeling for the stuff of action. In other cases, we may never have been aware of them. In both cases, however, we are usually unable to describe the knowing which our action reveals.*

Intuitive/tacit knowledge

Closely associated with this practical 'know how' is tacit knowing or intuition, which Polanyi (1967) has termed 'tacit knowledge', "*that which we know but cannot tell*" (Eraut, 1994:15). This reflects the intuitive knowledge embedded in practice which a practitioner holds but often has difficulty expressing verbally (Meerabeau, 1992). Benner (1982; 1984) argues that much expert knowledge is embedded in clinical practice and accrues over time. Practical and tacit knowledge are sometimes referred to as 'professional craft knowledge' (Higgs and Titchen, 1995).

Personal knowledge

Personal knowledge has three dimensions, firstly knowing oneself, secondly, that knowledge is personal to the individual knower and thirdly that it reflects knowledge of unique clients and situations acquired through personal encounter. Higgs and Titchen (1995:139) define personal knowledge as "*the unique frame of reference and knowledge of self which is central to the individual's sense of self. It is the result of the individual's personal experiences and reflections on these experiences.*" Indeed Rolfe (1998b:42) suggests that when a nurse uses reflection on action to consider a

particular client situation or experience, this results in personal knowledge, which he terms "*processed experience.*"

Experiential knowledge

It is interesting to note that both Heron's (1981) and Burnard's (1987) description of experiential knowledge appear very similar to the third form of personal knowledge, with experiential knowing being defined as the "*knowledge gained through direct personal encounter with a subject, person or thing. It is the subjective and affective nature of that encounter that contributes to this sort of knowledge. Experiential knowledge is knowledge through relationship" (Burnard, 1987:190).* This type of knowledge is therefore very personal and highly individual.The continuous process of experiential knowledge development is stressed by Kolb (1984). Rolfe (1998b:42) regards experiential knowledge as "*clusters of* [personal] *processed experiences*". He states that these two forms of knowledge, experiential and personal, are important in constructing personal theory, through a process of abductive reasoning, "*inference to the best explanation*" (Rolfe, 1998b:47) and reflection-in-action. He describes personal theory as "*a theoretical explanation of the problem I am faced with*" (Rolfe, 1998b:44).

2.12.3 Knowledge and professional practice

In his text 'Expanding Nursing Knowledge' Rolfe (1998b: ix) undertakes an exploration of the knowledge and theory, which informs clinical decision making and offers a model of professional judgement. This model proposes that professional judgement "*integrate*[s] *personal, experiential and scientific knowledge, reflection-on-action, reflection-in-action and personal theory in a process that both generates further knowledge and brings about changes to practice through the formulation and testing of personal theories*" (Rolfe, 1998b:54). Rolfe (1998b) describes the value of knowledge which is generated through personal experience and reflective practice, yet is critical of the technical rational approach to knowledge development. He argues that personal theory developed through personal and experiential knowledge has a much greater chance than scientific theory of being utilised successfully in practice, thereby reducing the theory/practice gap. Rolfe (1998a) stresses that his view of professional judgement

mirrors the perspective of Clarke et al. (1996) who regard nursing judgement as a combination of personal, experiential and scientific knowledge.

Rolfe (1998b:43) equates personal theory to a "*theory of practice*" which is "*personal to the practitioner*", unfolds solely through reflection-in-action and is unique to the situation from which it originates. This personal theory is generated by nurses working in clinical practice and is extremely influential in determining how a nurse responds to individual clients in unique situations. Rolfe (1998b:52) argues that professional judgement involves not only the development of personal theory but also the testing out of this personal theory, in action through "*praxis*" which he regards as the "*conscious manifestation*" of judgement. Rolfe (1998b:50) states that:

> *in testing a personal theory, the nurse is therefore also making a clinical intervention. She is formulating a hypothesis, based on her theory, of the probable clinical outcomes of certain actions, she is acting in accordance with that hypothesis and she is assessing whether the predicted outcomes have occurred.*

Thus Rolfe (1998b) believes that personal theories are short lived and that judgements are therefore dynamic and changing.

It is interesting to find that Bergen et al. (1996a) previously recommended the need for community practitioners to develop their capacity to effectively exercise sound professional judgement through a combination of "*phronesis*"- practical wisdom (Carr, 1995:71) and "*praxis*" (Carr, 1995:68). Johnson and Ratner (1997:3) have suggested that in its broadest sense praxis refers to "*practical human conduct*" and the kinds of knowledge used in this activity. Carr (1995) and Bergen et al. (1996a) present an argument that praxis involves much more than the development of practical skills, indeed Carr (1995) points out that practice in the Aristotelian tradition involves ethical, political and educational activity. Carr (1995:68) explains how the knowledge required for praxis differs from that needed for poiesis "*making something*". Firstly, the outcome of practice is not the production of an artefact or object but to effect some morally worthwhile 'good.' Secondly,

> *practice is not a neutral instrument by means of which this 'good' can be produced. The 'good' ... cannot be 'made', it can only be 'done'. 'Practice' is a form of 'doing action' precisely because its end can only be realised through action and action can only exist in the action itself.* (Carr 1995:68)

Finally Carr (1995) states that practice cannot be regarded as a form of technical expertise designed to fulfil an externally related end. Neither can these ends be determined in advance. He is critical of attempts to draw a distinction between theory and practice when the two are so clearly interwoven. Carr (1995) suggests that practice is a kind of morally committed or informed action.

Like Carr (1995), Eraut (1994) and Bryans (1998) are also critical of attempts to polarise and separate 'knowing how' to do something, from propositional/theoretical knowledge. Eraut (1994:43) has stated that:

> *the functional relevance of a piece of theoretical knowledge depends less on its presumed validity than on the ability and willingness of people to use it.*

Indeed Bryans (1998) emphasises how Eraut (1994) has criticised the over simplification of Schön's (1987) view of professional knowledge as being either technical rational or knowing in action. Bryans (1998:42) also criticises the "*unrealistic, polarising effect*" that these two views have on the use of professional knowledge in clinical practice. She draws attention to the need to acknowledge the important potential relationship between a practitioner's theoretical knowledge and practical know how. In fact Eraut (1985) states that it seems inappropriate to separate aspects of knowledge when much professional work involves utilising knowledge in an integrated way.

Bryans and McIntosh (1996) have also offered a description of knowledge used in community nursing practice as being either intrinsic or extrinsic. They state that when "*a nurse brings his or her own unique collection of prior knowledge and interpretive frameworks to any decision-making task*" (Bryans and McIntosh, 1996:25) this is known as intrinsic knowledge. Drawing on the research work of Luker and Kenrick (1992) they suggest that much of "*this intrinsic personally-owned knowledge is elusive and community nurses have difficulty in describing it*" (Bryans and McIntosh, 1996:25).

They define extrinsic knowledge as the type of knowledge which practitioners gather from external sources and which is easily identifiable and readily available.

In a study using complementary methods of simulated patient assessment and post simulation interview, Bryans (1998) examined the content and process of district nursing knowledge. This study revealed the breadth and range of knowledge used by district nurses when conducting a first assessment visit, this included biomedical and social knowledge, teaching and explaining knowledge, knowledge of resources, psychological and functional knowledge, as well as assessment and process knowledge in use. The study findings illustrated some of the implicit aspects of district nursing knowledge including "*procedural values and theoretical knowledge relating to how to manage an assessment interaction.*" (Bryans, 1998:296). Findings also revealed some of the unconscious aspects of nursing knowledge such as "*social and conversational rules and norms*" (Bryans 1998:295). Bryans (1998:304) does point out though that having considered only a single assessment encounter, this may not demonstrate district nurses flexibility in assessment, nor the true extent of their knowledge base.

In constructing a health visiting knowledge base, it is likely that practitioners will be influenced by a range of ways of knowing, utilising knowledge in an integrated way to make sense of practice experiences. A practitioner will weigh up and synthesise different aspects, including knowledge of the client, past cases, relevant research and theory and will "*assign different degrees of importance and relevance to the different pieces of knowledge*" (Rolfe, 1998b:47) which will inform professional judgement in practice settings.

2.13 Conceptual frameworks for studying judgement and decision making.

There are many different models and theoretical perspectives for examining clinical judgement, clinical reasoning and decision making processes. Research in these areas has been conducted in many different disciplines, including psychology, economics, nursing, physiotherapy, occupational therapy and medicine. A notable exception is the field of health visiting, where only one study has focussed primarily on practitioner

decision making (Lemmer et al, 1998). It is also interesting to note that few studies have focussed specifically on the concept of professional judgement. This review has already highlighted the apparent interrelated nature of the concepts of clinical judgement, reasoning and decision making and the fact that in practice the terms are often inextricably linked. Likewise, there are a plethora of theoretical perspectives, models and exemplars used to illustrate particular theories evident in the literature in the exploration of these concepts. In view of this fact, it seems pertinent to provide an overview of the different theoretical perspectives and methods which exist in the literature for studying these concepts, as well as highlighting their potential value for health visiting research in this area.

The particular components which are emphasised in models and theories of judgement/decision making tend to reflect one or more of the following factors:

- the theoretical perspective of the researcher or theorist
- the component of the judgement/decision making process being studied
- the nature of the judgements/decisions under consideration
- the variables which impact on the processes/outcomes of judgements and decisions. (Tanner, 1986; Bryans and McIntosh, 1996)

Two broad theoretical approaches for studying these concepts emerge from the literature, these are the rationalist/scientific perspective and the intuitive/interpretive approach. Furthermore with recent advances in medical technology and treatment, there is an increasing emphasis on the ethical and moral aspects of health care decision making (Mahon and Fowler, 1979; Candee and Puka, 1988; McHaffie and Fowler, 1997a and b; Almond, 2001), as well as the client/patient perspective (Caress, 1997; Entwistle et al, 1998).

2.13.1 Rationalist perspective

The rationalist perspective adopts logical and systematic methods to gather and analyse data in a conscious, linear reasoning process. Using all available knowledge an analysis of the situation is undertaken, various courses of possible action and their probable outcomes are carefully considered in order to reach the best possible

decision (Luker et al, 1998). The resulting action is selected from a number of alternatives in a rational and logical manner and the cognitive strategies and knowledge applied in the judgement process are made explicit (Tanner, 1987; Harbison, 1991; Baker, 1997). Rational decision-making theory assumes that the same thought processes can be applied to different clinical situations and that "*rational-analytic thinking precedes activity*" (Lauri et al, 1997:146). However, as Luker et al. (1998:658) point out:

> *not all knowledge is always available, [therefore] some decisions will have to be made in conditions of uncertainty, and with an element of risk involved in the decision.* (Miers, 1990; Harbison, 1991; Wurzbach, 1991)

A number of models have been used to illustrate the rationalist perspective, these include: decision analysis, information processing models and diagnostic reasoning models, incorporating the hypothetico-deductive method. Tanner (1987) has stated that studies using the rationalist perspective have tended to adopt one of two approaches either:

- a description of the practitioners cognitive processes in making a diagnosis or deciding on a particular course of action, or
- have contrasted a practitioner's performance in forming a decision with that of a statistical model.

Decision analysis theory

Decision analysis theory was initially applied to medical clinical problem solving (Fonteyn, 1995), before being utilised in a number of nursing research studies (Grier, 1976; Aspinall, 1979; Hughes and Young, 1990). Its purpose is to describe how practitioners will select a particular course of action (Tanner, 1986). Harbison (1991:405) has described how in decision analysis:

> *a model of the problem is constructed, showing the available options ... and the consequences of following each. An attempt is then made to assign a probability to possible outcomes ... Each possible outcome is assigned a value which reflects the desirability of the outcome ... By combining the probability with the assigned value, the 'expressed value' of each option is then obtained: the option with the highest 'expected value' is the best option to choose.*

Decision analysis is frequently depicted by tree like diagrams known as 'decision trees', which illustrate the choices open to the decision maker, with each potential decision and its estimated outcome being illustrated. In a study using hypothetical patient case studies, Aspinall (1979) found that nurses who used a decision tree to form a judgement about a patient's condition had an improved accuracy in making a correct diagnosis, compared to nurses not using 'decision trees'. Indeed there appears to be an increasing interest in this model with the current evidence based practice movement (Dowie, 1996).

Information processing theory

Another method for examining rational decision making is the information processing theory (IPT) which originated from Newell and Simon's (1972) work in artificial intelligence. In this theory individuals are regarded as information processing systems. The theory is based on the assumption that people are limited in the amount of information that they can process at a particular point in time and that effective problem-solving involves being able to adjust to such limitations (Tanner, 1986; Fonteyn, 1995). IPT is concerned with short and long term memory and involves the decision maker clustering similar pieces of information together and generating hypotheses to explain the data gathered (Radwin, 1995).

According to Lauri et al. (1997:146-147) it involves:

> *continuous accumulation of information using different methods and observation of clues arising from these situations; checking information and clues received and activating assumptions in relation to one's previous knowledge; ascertaining, testing, and interpreting assumptions and defining problems on this basis; and planning activity relating to problem solving in relation to one's own earlier knowledge.*

In these types of models nurses have to make rational choices on the basis of multiple patient variables and separate relevant from irrelevant data. This approach focuses on the nurse's "*ability to meaningfully organise and rapidly chunk information in short and long term memory*" (MacLean, 1989:73; Tschikota, 1993).

Many of the studies informed by IPT adopt either concurrent or retrospective verbal protocol methods (participants think aloud while completing cognitive tasks) related to simulations, video material or written case studies in an attempt to describe reasoning strategies (Corcoran, 1986 a and b; Grobe et al, 1991; Fonteyn et al, 1993). However, these approaches have been particularly criticised for their failure to capture the contextual reality in which judgements occur (Baker, 1997). Although in an attempt to address this problem a few studies have incorporated concurrent verbal protocol methods in practice situations (Greenwood and King, 1995), yet there are clear ethical concerns around this approach (Jones, 1989). Other criticisms include the fact that participants may explain their behaviour in a different way to what has been observed, and that retrospective verbal protocol methods may be affected by memory (Rivett and Higgs, 1995).

Diagnostic reasoning models

A model of diagnostic reasoning, based on information processing theory and frequently cited in the literature is that of Elstein et al. (1978), who describe the reasoning processes of doctors to include four major strategies. These are:

- interpreting cues
- diagnostic hypothesis generation
- data collection influenced by the hypotheses generated (to confirm or refute the hypotheses)
- hypothesis evaluation (Elstein et al, 1978; Tanner, 1987).

These researchers found that novices and experienced doctors attempted "*to generate hypotheses to explain clusters of findings, although the content of the experienced group's productions were of higher quality*" (Elstein, 1995:50). A number of studies have examined hypothesis generation through the hypothetico-deductive method and it has been a particularly popular approach in medical research (Groen and Patel, 1985). Tanner et al. (1987) undertook a study to determine whether Elstein et al's (1978) model of diagnostic reasoning was applicable to qualified and student nurses. These researchers found that all participants activated hypotheses early in the decision making process.

In contrast, Fonteyn's (1991;1995) study of expert intensive care nurses found that most nurses' reasoning activities are not focussed towards diagnosis and hypotheses generation. Instead she found that nurses used heuristics to make judgements about the significance of patient assessment data, by deciding on its relevance to a patient's overall treatment and nursing care plan. Indeed the literature raises several doubts about the hypothetico-deductive approach including the "*marked cognitive effort*" required to generate hypotheses and the possible bias from too few hypotheses being generated too early in the reasoning process (Jones, 1988:188). Bryans and McIntosh (1996) are also critical of this model for ignoring 'predecisional activity' (Carroll and Johnson, 1990). While evidence from research in cognitive psychology suggests that the hypothetico–deductive method is characteristic of novice as opposed to expert performance (Groen and Patel, 1985) and is only adopted by experts when dealing with unfamiliar problems (Rivett and Higgs, 1995).

Kahneman et al. (1982) have found that people regularly use heuristic principles for estimating the probability of certain outcomes particularly when dealing with complex problems. Heuristics have been described as "*short cuts in thinking*" (O'Sullivan, 1999:90) or "*rules of thumb*" (Cioffi and Markham, 1997:266) to speed up and reduce the complexity of reasoning processes. Commonly used heuristics include representativeness, availability, anchoring and adjustment (Tversky and Kahnemnan, 1974). Representativeness involves making a judgement that "*the probability that certain signs and symptoms in patients indicate a particular clinical condition that the nurse has previously encountered*" and easily recalls (Cioffi and Markham, 1997:266). Availability is concerned with the ease of recall of similar events. In anchoring and adjustment, the practitioner begins from a baseline and adjusts this point to take into consideration new information before reaching a final estimate or probability (Tversky and Kahnemnan, 1974). However, it is important to point out that while heuristics may facilitate judgement strategies, they can also lead to biases and errors of judgement (Baumann and Deber, 1989).

Several researchers have suggested that the nursing process, with its focus on linear and progressive steps has its roots in a rationalist perspective (Harbison, 1991;

Watkins, 1998). Yet its adequacy for examining complex judgement processes in both nursing and health visiting practice has to be questioned. Benner (1984:38) has stated that such "*process models cannot describe the advanced levels of clinical performance observable in actual practice.*" This may be one of the reasons that the nursing process is not routinely used in health visiting practice.

Criticisms of the rationalist perspective

Overall rationalist models can be criticised for being highly mechanistic and for excluding variables such as cultural factors and patient/client personality which might have an important impact on judgement processes (Baker, 1997). These models certainly do not sit easily with health visiting's client centred and public health philosophy. On the whole they tend to rely on "*the creation of pseudo clinical situations*" (Baker, 1997:42), which do not reflect reality. Decision analysis models have been criticised for their close affinity to the medical and scientific model (Baumann and Deber, 1989; Orme and Maggs, 1993; Bryans and McIntosh, 1996) and for their prescriptive nature. For rational decision theory to be beneficial there has to be a correct answer (Bryans and McIntosh, 1996) and as Watkins (1998:23) states:

> *there must be a high degree of predictability about a health problem so that statistical values can be assigned to variables necessary to determine probabilities.*

The highest degree of diagnostic accuracy is likely to occur when data comes from diagnostic laboratory tests and not from patient assessment or physical examination (Aspinall, 1979). In health visiting, much of the quantitative data required for probability estimates is unknown as there is often no 'right answer' or 'end point', and it would be unreasonable to expect to identify such information (Jones, 1988; Bryans and McIntosh, 1996).

To adopt a rationalist approach in the study of health visitor professional judgement would clearly be problematic. Here the central focus of the work is not about the discovery of diagnoses or dealing with 'patient problems', but on health promotion work, often involving long term assessment (Bryans and McIntosh, 1996; Cowley et al, 2000b). Furthermore health visiting rarely concentrates solely on the individual

but on the whole family unit. In community nursing very little is predictable. Health visitors are constantly dealing with uncertain and complex situations. Indeed it is impossible to predict individuals' behaviour when health visitors are dealing with such unique situations. Furthermore none of these studies appear to take account of the client viewpoint in generating sound judgement and decision making.

2.13.2 Intuitive – Interpretive perspective

The second broad approach to the study of judgement and decision making has been called the phenomenological (Tanner, 1987; Harbison, 1991; Baker, 1997; Martin, 1999), intuitive (Luker et al, 1998; Watkins, 1998) or interpretive tradition (Patel and Arocha, 1995). This approach adopts the view that judgement is based on practical and intuitive knowledge drawn from previous experience and is dependent on the unique characteristics of the decision maker. It examines judgement and decision making in 'real life' contexts adopting a holistic focus. Action precedes analytical thinking, as the decision maker searches for and uses patterns and connections in the whole context (Tanner, 1987). "*Rather than reducing the situation to discrete elements; knowledge is embedded in, and derives from, practice*" (Harbison 1991:405). This type of study acknowledges the importance of reflective activity in discovering patterns and recognises the impact of gut-feelings and past experiences on judgement and decision making processes (Benner and Tanner, 1987; Tanner, 1987).

This approach is exemplified through the work of Benner (1982; 1984), who sought to examine the knowledge, judgement processes and clinical performance of expert and beginning nurses, by applying the four aspects of skilled performance found in the Dreyfus and Dreyfus (1986) model of skill acquisition. An important feature of this model identified the movement from analytical thinking to intuitive decision making, which appears to develop as a practitioner reaches an expert level of expertise. Benner (1982; 1984) used interviews and participant observation strategies to explore how expert and beginner nurses managed clinical situations. She found that expert nurses had developed an intuitive grasp of patients' situations, by focussing on the whole situation and drawing on knowledge from extensive clinical practice experiences.

Benner and colleagues (1992) studied the Dreyfus and Dreyfus (1986) model further within the field of intensive care nursing and again endorsed this fundamental principle of skilled performance. Benner et al. (1996:142) state that:

> *expert practice is characterised by increased intuitive links between seeing the salient issues in the situation and ways of responding to them.*

These researchers found that the judgements and perceptions of the expert nurse were different from those with different levels of expertise. The intuitive grasp of the expert allowed the focus to shift from an emphasis on problem identification and an adherence to procedures and guidelines, to consideration of interventions required (King and Appleton, 1997).

Pyles and Stern (1983) completed a small scale study to find out how expert critical care nurses determine if a patient is developing cardiogenic shock and what assessment and decision making processes they use. Twenty-eight critical care nurses were studied using a grounded theory approach; unlike Benner's (1984) study no attempt was made to differentiate between the nurses on education or clinical experience grounds. Pyles and Stern (1983) identified what they called a 'nursing gestalt', a matrix in which the nurses linked together knowledge, past experiences, patient cues and gut feelings. This study illustrated how nurses attempted to take in "the whole picture" and appears similar to Benner's findings, where the expert nurse using intuitive skills is able to immediately grasp and understand the complete situation (Benner, 1984).

It is important to point out that many studies in the interpretive tradition have attempted to contrast the judgement processes of experts and beginner nurses to highlight the decision making qualities of the expert. However this approach has been criticised for its failure to explicate in detail the judgement processes of less experienced nurses and for omitting to examine the various elements which affect the actual development of the expert's judgement (Baker, 1997). There is also some debate in the literature about the extent to which intuitive processes are regarded as conscious or unconscious (Eraut, 1994; Eason and Wilcockson, 1996a, 1996b). For

example, Rolfe (1998b:51) is critical of Benner's (1984) view of the expert nurse with her unknowable intuitive grasp who "*cannot justify her decisions.*" He argues that because the expert nurse is unable to explain how she reaches a decision, she is unable to consciously draw on past experiences and prior knowledge to enhance her decision making skills. Rolfe (1998b:49) states that judgements are not made on an "*unknowable intuition, but on an inductive probability arrived at by weighing up all the available personal, experiential and scientific knowledge through the process of abductive reasoning.*"

In a critical review of the literature, King and Appleton (1997) highlighted the growing body of empirical evidence, which illustrates that intuition is a crucial aspect of the nursing judgement process. These authors describe how:

> *intuition occurs in response to knowledge, is a trigger for nursing action and/or reflection and thus has a direct bearing on analytical processes in patient/client care.* (King and Appleton, 1997:201)

Influential factors in the judgement process

Recent theoretical and empirical literature indicates that judgement is neither a purely rational or intuitive-experiential process, but incorporates both elements in conjunction with practitioner knowledge, skills and experience (Lauri and Salanterä, 1995; Higgs and Titchen, 1995; Bryans and Macintosh, 1996; Easen and Wilcockson, 1996a and b; Watkins, 1998). Hamm (1988) drawing on Hammond's (1978) Cognitive Continuum Theory describes how 'intuitive art' and 'rational science' thinking should be viewed not as separate entities but as two ends of a continuum. He suggests that as much thinking is neither purely intuitive nor purely analytical, most cognitive processes occur somewhere between the two and incorporate both elements. The less structured a task is, then the nearer to the intuitive end of the continuum the decision will be, the more structured, the nearer it will appear to the analytical end (Hamm, 1988). This position is also supported by Thompson (1999). Furthermore Lauri and Salanterä (1995) describe how many nursing research studies illustrate how decision making stages such as data gathering, processing, analysis, plans for

intervention and monitoring are integrated and do not progress in a linear fashion (e.g. Corcoran, 1986a and b; Grobe et al, 1991; Benner et al, 1992).

The literature also indicates that there are many factors that have the capacity to influence nursing judgement and decision making. These include: the nurse's knowledge and clinical experience (Baumann and Bourbonnais, 1982; Benner, 1982, 1984; Wooley, 1990; Hughes and Young, 1990; Jacovone and Dostal, 1992; Watson, 1994; Ainsworth and Wilson, 1994; Lauri and Salanterä, 1995; Bryans and McIntosh, 1996; Luker et al, 1998), the nurse's personal values belief systems and attitudes (MacLean, 1989; Hamers et al, 1994), levels of support available to nurses in their working environments (Orme and Maggs 1993), their knowledge of the patient/client (Jenks, 1993; Radwin, 1995), pressure from patients (Luker et al, 1998), the amount of time and number of different choices available for making a decision (Payne, 1982), factors within the context that constrain/construct decisions (Cowley, 1991), influence from drug company representatives (Luker and Kenrick, 1992), the nature of the nursing task and context (Lauri and Salanterä, 1995) and rapidly changing contexts (Benner, 1994; Thompson and Sutton, 1985).

2.14 Judgement and decision making – Research in community nursing

The majority of research studies on judgement and decision making have been conducted in hospital settings. Although only one study has focussed primarily on health visitor decision making (Lemmer et al, 1998), judgement and decision making has been addressed indirectly in a number of studies exploring needs assessment in community nursing. This section will therefore critically review research examining professional judgement and decision making from the wider community nursing perspective, incorporating data from the UK, Europe, America and Australia to inform understanding about the key research themes. (See Table 2.4).

It is interesting to find a recent methods paper reporting a 'systematic review of non-random and qualitative research literature' undertaken by Lemmer et al. (1999) and focussing specifically on the evidence base for health visiting and decision making.

Table 2.4: Summary of research papers on professional judgement and decision making in community nursing.

Research study	Origin of study	Focus of paper	Sample	Theoretical approach/model
Wheeler (1989)	UK	A study to examine how HVs and social workers undertake family assessments in child protection	5 health visitors 5 social workers	Phenomenological study using in-depth interviews with health visitors and social workers
White et al. (1992)	USA	An examination of the content and process of clinical decision making by nurse practitioners	27 nurse practitioners	Hypothetico-deductive reasoning process, diagnostic hypothesis generation using computer-simulation of patient and interactive video
McMurray (1992)	Australia	A study to examine expertise and judgement processes in novice and expert community health nurses	9 expert nurses from each discipline of school health, child health and district nursing and 10 novices, 5 child health and 5 district nursing sisters	Qualitative interpretive approach
Luker and Kenrick (1992)	UK	A study to examine the sources of influence on clinical decisions relating to nurse prescribing	47 community nurses: including 33 district nursing sisters, 7 DN ENs, 3 specialist nurses, 2 practice nurses, 2 DN students	Qualitative method - participant observation of home visits and nurse run clinics and subsequent semi-structured interviews. Also group discussions and analysis of nursing records
Orme and Maggs (1993)	UK	A study to examine how expert nurses, midwives and health visitors make decisions in practice	12 experts	Qualitative exploratory study using focus groups interviews
Appleton (1993)	UK	A study to explore health visitors assessments of vulnerable families	Postal survey of 102 HVs, response rate 57% and interviews with 12 HVs.	Broadly qualitative approach; survey and in-depth qualitative interviews
De la Cruz (1994)	USA	A study to describe the decision making styles of home health care nurses	21 home health care nurses	Grounded theory study. 10 nurses accompanied on home visits. Observations of nurse-patient-care giver interactions, interviews pre and post visits
Lauri and Salantera (1995)	Finland	To examine nurses and public health nurses use of decision making models	Random sample of 100 public health nurses and 100 nurses working in in-patient clinics	Information processing theory and interpretive/ intuitive theory - Dreyfus model of skill acquisition in nursing. Data collected through a 56 item Likert-type structured questionnaire
Bryans and McIntosh (1996)	UK	Theoretical discussion paper on the application of Carroll and Johnson's (1990) 7 stages of decision making	Literature	Theoretical discussion paper

Table 2.4 (continued): Summary of research papers on professional judgement and decision making in community nursing.

Research study	Origin of study	Focus of paper	Sample	Theoretical approach/model
Bergen et al. (1996a,b)	UK	A study to examine how community nurses make health needs assessments	32 recently qualified health visitors and district nurses	Case study
Carney et al. (1996)	UK - Scotland	A study to explore methods of needs assessment in health visiting	Survey of 467 mothers, interviews with 26 clients, 16 health visitors and 33 social workers	Complementary methods used including the Nominal Group Technique, recording of non-protocol encounters, monitoring of referrals, interviews and survey
Lauri et al. (1997)	Finland, Norway, Canada and USA	To examine public health nurses use of decision making models across 4 countries	369 public health nurses: Finland - 102 Norway - 102 Canada - 72 USA- 93	Information processing theory and interpretative/ intuitive theory - Dreyfus model of skill acquisition in nursing. Data collected through a 56 item Likert-type structured questionnaire
Watkins (1998)	USA	A study to examine the decision making processes of expert nurses working in urban community health settings	Purposive sample of 28 community health nurses	A qualitative exploratory study influenced by intuitive decision making theory. Method involved the description of a critical incident and interviews
Lemmer et al. (1998)	UK	A Delphi survey to examine health visitor decision making	Successive survey of an expert panel. No indication of sample size. Random sample of 250 health visitors - no indication of response rate	Acknowledges different theories of decision making. Delphi surveys to expert panel and repertory grid questionnaire to health visitors
Offredy (1998)	UK	A study to examine the decision making frameworks used by nurse practitioners working in general practice	20 nurse practitioners	Retrospective verbalisation and observation to examine four decision making strategies: Hypothetico deductive method, decision analysis, pattern recognition and intuition
Lemmer et al. (1999)	UK	Systematic review of nonrandom and qualitative research literature on HV decision making	Research Literature	Systematic review

Unsurprisingly this review found an absence of randomised controlled trials in this area, focussing instead on "*theoretical studies of decision making and practice-based research*" (Lemmer et al, 1999:315). Yet despite its intended focus on decision making, it is startling to find that this systematic review did not use the following key words in its search strategy:- judgement, professional judgement, clinical judgement and clinical reasoning. The paper can also be criticised for its uninformed comments about the majority of health visiting research studies focussing on "*procedures*" (Lemmer et al, 1999:324), as the authors clearly do not regard assessment of family vulnerability (Appleton, 1995), searching for health needs (Chalmers, 1993). marketing (De la Cuesta, 1994a) and gaining access to clients (Luker and Chalmers, 1990) as involving anything other than procedural knowledge. Furthermore the authors' apparent scepticism about studies reporting the use of intuitive processes in health visiting, appears to demonstrate a propensity towards rational theories of decision making.

One of the first British studies to examine how health visitors and social workers undertake family assessments was conducted by Wheeler (1989) using a phenomenological approach. She used a small sample of 5 health visitors and 5 social workers to investigate these professionals' perceptions of their work in child protection. Wheeler's (1989; 1992) findings suggest that both professional groups use a similar assessment process. She identified several key assessment categories, including intuition, personal standards and life experiences, assessing interpersonal relationships between family members and physical factors of the home/environment. Wheeler (1989) found that it was assumed that professionals would have "*a common understanding*" and "*shared knowledge*" of definitions of child abuse, but in fact this was not the case. This contrasts with Fox and Dingwall's (1985) vignette study where health visitors and social workers were in close agreement about the relative seriousness of child abuse incidents.

White et al. (1992) conducted a study to increase understanding about nurse practitioners' clinical decision making. A convenience sample of 27 nurse practitioners, 21 of whom were family nurse practitioners and 6 obstetric/gynaecology

nurse practitioners participated in the study. All practitioners were asked to care for the same patient via computer-simulation and interactive video, in which they "*were able to interview the patient by typing in questions in their own words*" (White et al, 1992:155). The patient's history, physical examination and laboratory test findings were based on a real patient who presented with a genital rash and vaginal discharge. Findings indicated that all nurses adopted the hypothetico-deductive approach to decision making, with the obstetric/gynaecology nurses most likely to make the correct diagnosis, using a "*symptom driven*" approach. However this hypothesis driven approach does seem to have been pre-empted by the research design as participants were required to list diagnostic hypotheses at each stage of the patient simulation. Furthermore the researchers highlight some of the limitations of simulated patient situations, including the fact that decision making processes may differ markedly in real life clinical practice.

In an Australian study examining clinical expertise in novice and expert community health nurses, McMurray (1992) adopted a different, interpretive approach, using in-depth interviews, participant observation and written retrospective accounts of clinical care. Participants included 9 expert nurses from each discipline of school health, child health and district nursing and 10 novices, 5 from child health and 5 from district nursing. McMurray (1992) found that all participants adopted similar practice behaviours directed at self and client management. The former centred on planning the caseload, information and time management, while client management focused on establishing contact and developing a rapport with clients, in order to search out and assess clients' needs. During assessment interviews the nurses responded to cues which formed the basis of their clinical judgements. McMurray (1992:67) suggests that the judgement process involves:

> *attending to these cues, judging the situation, validating judgements with the client and setting priorities for meeting the needs of the client.*

Although McMurray (1992) found a number of client situations where the judgement processes of novices and experts appeared similar, she found no significant differences in judgement process across the three disciplines of community health nurses.

However she did discover that "*a profile of the expert emerged which clearly demonstrated superior processes in judging clinical situations*" (McMurray, 1992:67) and a greater self-confidence in making judgements. Unfortunately she does not explain how the data were analysed for differences, but states that many of the processes were similar to those previously identified by Benner and Tanner (1987) including four stages of the "*diagnostic process: narrowing the search field, hypothesis activation, information seeking and hypothesis evaluation*" (McMurray, 1992:67-68).

One of the early British studies to examine community nurse decision making was a qualitative study by Luker and Kenrick (1992) prompted by the UK nurse prescribing initiative. This study undertook to examine the sources of influence on the clinical decisions made by 47 community nurses working in four different health authorities. A convenience sample was used and data collection involved multiple strategies including semi-structured interviews, participant observation of home visits/nurse run clinics, group discussions and analysis of nursing records. Observation data provided the focus for the subsequent semi-structured interviews.

Content analysis of study data revealed 35 sources of influence on clinical decision making which were informed by:

- *knowledge based on research and tested theories*
- *knowledge based on practice and arising out of nursing experiences*
- *knowledge which is common sense and current in everyday life.*

(Luker and Kenrick, 1992:459)

Clinical decisions were classified as:

- *clinical-technical procedures*
- *clinical-support procedures*
- *social-support procedures*
- *educational procedures.*

(Luker and Kenrick, 1992:459)

Analysis of study data revealed that only three sources of influence on clinical decision making could be classified as research based knowledge. Instead the nurses

highlighted 'past experience' and 'situational variables', both regarded as practice-based knowledge as important factors influencing their decisions. The practitioners also valued experiential knowledge in the form of discussions with other nurses. Luker and Kenrick (1992) acknowledge the methodological limitations of the study that in separating "*experiential or practice-based knowledge from scientific or research based knowledge*" they may have created "*an artificial distinction which inhibits the development of an integrated nursing knowledge base*" (Luker and Kenrick, 1992:463). Indeed these authors question whether community nurses might be reclassifying scientific knowledge as experiential knowledge. Although all the community nurses demonstrated high levels of practical skills only two could fully articulate the reasoning behind the decisions they had made.

In 1993 Orme and Maggs conducted a small qualitative study to examine how expert nurses, midwives and health visitors make decisions in practice. The sample included twelve practitioners and a focus group interview approach was used. The group spent two days exploring clinical decisions and trying to illuminate the common and specific factors which form decision making processes. Findings suggest that a major contributory factor to effective decision making is a well defined "*philosophy of care*" addressing legal, ethical, moral and resource dimensions. These authors argue that "*without such a philosophy, decisions will be arbitrary, uninformed and perhaps unsafe*" (Orme and Maggs, 1993:275).

Participants agreed that expert-decision making is dependent on a sound knowledge base, experience of care provision and evaluated research evidence relevant to a particular client group. These professionals endorsed the use of professional judgement and the importance of nurse and patient intuition in the process of collecting data to reach a decision. However, the participants did point out that student and newly qualified nurses also experience gut feelings, though they are often criticised for voicing them. The group felt that nurses should be encouraged to voice gut feelings to deepen their knowledge base and synthesise their decision making. Findings from this study and earlier research work suggest that intuition may not lie only in the domain of the expert practitioner (Benner 1982, 1984; Benner and Tanner, 1987; Benner et al, 1992).

The nurses in this study felt that expert decision making involves the ability to make sense of complex situations, to distinguish relevant cues and pace a decision accurately. Expert decision making may involve an element of risk taking and can only take place effectively in a supportive environment.

> *Previous experience of similar situations is valuable but this does not override the need for flexibility and the ability that each new situation may require a different decision.* (Orme and Maggs, 1993:273)

The expert group specified a number of stages in the decision making process:-

Stage 1 The establishment of a philosophy of care to support effective decision making.

Stage 2 Determining the need for a decision by the individual practitioner.

Stage 3 A holistic assessment.

Stage 4 Examining all possible actions

including client and practitioner intuitive feelings ethical, moral and legal issues, available resources, knowledge and research findings, conflicts of interest, code of professional conduct, views of nursing and multi-disciplinary teams and past experience of similar situations.(Orme and Maggs, 1993:274)

Stage 5 Decide on course of action and rationale supporting decision.

Stage 6 Take action and monitor its effect.

Stage 7 Reflect on the process and outcome of decision making.

(Adapted from: Orme and Maggs, 1993)

A study was conducted to examine health visitor decision making in exploring how health visitors identify and work with vulnerable families (Appleton, 1993). The method incorporated a two stage approach including a postal survey of 102 health visitors with a response rate of 57%, followed by in-depth qualitative interviews with 12 of the participants. Data analysis revealed six inter-relating factors reflecting the steps which health visitors use when assessing family vulnerability. These include:

- knowledge of families/the community
- situations/families that cause anxiety or concern
- reflection-on-action
- past history of a family
- professional judgements based on health visitors' knowledge base and experiences
- health visitors' gut feelings/instinct (reflection-in-action).

This latter category is an important finding as both Wheeler (1992) and Orme and Maggs (1993) had previously identified the use of intuition in health visitors' family assessments. More recently Goding (1997) has described how health visitor intuition can influence needs assessment. Appleton's (1993) study also indicated that some health visitors, while admitting to using gut feeling in their family assessments, were concerned that they should not be using it, because of the difficulties inherent in rationalising and articulating the concept. Some health visitors were also concerned about the legal implications of using intuition. This study highlights an ongoing theme of devaluing intuitive judgement.

De la Cruz (1994) sought to describe the decision making styles of 21 American home healthcare nurses (with a similar function to UK district nurses) through a grounded theory study. Nurses were interviewed pre and post home visits and were observed during nurse-patient-caregiver interactions in patients' homes (De la Cruz, 1994). Content analysis of documentary evidence relating to patient records, nursing practice policies and procedure manuals was also undertaken. Data analysis revealed three different decision making styles "*skimming, surveying and sleuthing*" (De la Cruz, 1994:222) which appeared to be influenced by the nurses' experience and knowledge, the patient and the decision making situation. 'Skimming' reflects task-orientated care. It involves the nurse completing pre-determined and clearly defined tasks and delivering minimum service requirements. When adopting the 'surveying' style nurses gathered patient data in a logical and systematic way, often guided by assessment forms and documentation. This style of decision making is adopted when dealing with "*routine, recurrent, and well-structured patient-care situations characterised by a high level of agreement as to their attributes, solutions, and consequences*" (De la Cruz, 1994:224). The author states that this resembles Schön's (1983) description of the "*high, hard ground*" of clinical practice.

Experienced nurses used 'Sleuthing' when dealing with complex and ambiguous patient situations or ill-defined problems. De La Cruz (1994) suggests that these situations can be compared with Schön's (1983) view of the "*swampy and messy lowlands*" of clinical practice. In these situations nurses would search for clues without referring to assessment guidelines. They would be guided instead by their

intuition, searching for links in patient data, using questioning to gather relevant information and observing non-verbal cues. De la Cruz (1994:224) also found that experienced nurses used heuristics in managing patient situations. In dealing with different clinical situations, De la Cruz (1994) found that experienced nurses were able to move from one decision-making approach to another, which she states supports the cognitive continuum theory (Hamm, 1988), however she failed to provide a definition of the 'experienced nurse'.

Lauri and Salanterä (1995) took a very different approach to examine Finnish nurses' and public health nurses' use of decision-making models. The study involved a random sample of 100 public health nurses working in community health centres, focusing on preventive health care and 100 hospital nurses working in in-patient clinics. A 56 item Likert-type structured questionnaire was developed, with "*half of the items describ[ing] a systematic-analytical and rule-based approach to decision-making, and half a holistic-interpretive approach*" (Lauri and Salanterä, 1995:522). The questionnaire was informed by the two theoretical perspectives of information-processing theory (Newell and Simon, 1972) and the Dreyfus model of skill acquisition as applied in nursing (Benner, 1984). It "*was designed to reflect nursing knowledge, practical experience and nursing context*" (Lauri and Salanterä,1995:522). It addressed 4 stages of the decision making process "*data collection, data processing and identification of problems, plans of action, and implementation of plan, monitoring and evaluation*" (Lauri and Salanterä,1995:522), but interestingly did not acknowledge any predecisional activity (Bryans and McIntosh, 1996).

The study results revealed four different types of decision making:

- *unquestioning/questioning decision making*
- *creative-diversive decision-making*
- *patient/nurse oriented decision making*
- *rule and situation based decision making.*

(Lauri and Salanterä, 1995:520)

The most important features relating to decision making were the nature of the task and context and the nurses' experience. Study data revealed that the hospital nurses were nurse orientated and unquestioning in their decision-making whereas public health nurses were more patient oriented and questioning.

The least experienced public health nurses and hospital nurses adopted a questioning approach to decision making and their information gathering tended to be nurse-orientated. However, when nurses had more than 6 years of experience their approach to decision making was more patient orientated. Experienced nurses applied decision-making models that contained features of both systematic-analytical and holistic-interpretive approaches. Lauri and Salanterä (1995:526) state that the findings support those of Tanner et al. (1987) who found that:

> *with an increased level of experience, there was also a trend toward more systematic data acquisition and greater accuracy in diagnosis.*

In a theoretical discussion paper Bryans and McIntosh (1996) examine decision making in community nursing practice using the stages of decision making outlined by Carroll and Johnson (1990). The seven stages included "*recognition, formulation, alternative generation, information search, judgement or choice, action and feedback*" (Bryans and McIntosh, 1996:25) and the paper discusses the relevance of each of these stages to community nursing assessment, practice and research. The authors particularly emphasise the importance of the preliminary and predecisional stages of decision making 'problem recognition and formulation' involving "*exploration and classification of the situation by the decision maker*" (Bryans and McIntosh, 1996:25). This stage is often ignored in decision making models, yet Bryans and McIntosh (1996) regard this as an integral part of community nurse decision making.

Bryans and McIntosh (1996) are critical of systematic approaches to nursing care which imply that all nurses will assess patient needs in the same way. These authors highlight the importance of considering the practice context when examining decision making in community nursing practice and emphasise the unstructured nature of

many of the problems facing community nurses. They describe the ongoing and continuous nature of much community nursing assessment (Cowley et al, 1995), which they state is equivalent to Barrows and Feltovich's (1987:86) view of doctor's reasoning which involves "*a temporal unfolding of information.*" These authors argue that it is extremely important to take this fact into account when designing studies to examine decision making in community nursing. Bryans and McIntosh (1996) suggest that many medical models of decision making are not useful for addressing issues in community nursing. They state that "*if models are not to limit and constrain a researcher they must be broad and inclusive of the realities of the area being researched*" (Bryans and McIntosh, 1996:28). Bryans and McIntosh (1996) conclude by stating that Carroll and Johnson's (1990) model of decision making provides a useful framework for exploring aspects of community nursing assessment practice.

In a large ENB funded study, Bergen et al. (1996a and b) investigated the educational requirements of community nurses with regard to needs assessment, in an attempt to identify models of good clinical practice. These researchers conducted focus group discussions and a multiple case study where 32 recently qualified health visitors and district nurses were observed during a practice shift and were interviewed about their health needs assessments. The data revealed that when assessing health needs practitioners often faced difficult situations and ethical dilemmas relating to differing perceptions and priorities. Bergen et al. (1996a:239) suggested that as a result community nurses need to develop both "*a deeply ethical and practical wisdom (phronesis;* Carr, 1995*), the ability to incorporate theoretical perspectives into everyday thinking (praxis;* Carr, 1995*) and to integrate finely judged decisions into practice.*" These researchers argued that community practitioners need to develop "*high-level skills*" to be able to deal with complex needs assessments in a range of situations: and that education should focus on developing a practitioner's ability to make sound professional judgements. They suggest that to gain suitable experience in needs assessment and critical thinking, community practitioner preparation courses may need to be lengthened.

Carney et al. (1996) conducted a study to explore methods of assessment of need for health visiting, in two contrasting areas of a city in West Scotland. A variety of data collection methods were utilised including a self-completion questionnaire for monitoring non-protocol visits and clinic contacts over a four month period, a case finding survey of 467 mothers of children aged 1-2 years and interviews with 26 clients, 16 health visitors and 33 social workers. One of the key findings of this study was that the health visitors appeared to identify different types of health needs depending on the area in which they worked. In the deprived areas health visitors used social and economic factors in their rationale to visit clients and they did this more frequently than colleagues working in more affluent areas. The researchers also recommended that the Health Board's visiting protocol (reflecting minimum standards of service provision) should not "*be used as a basis for assessing need on a population basis*" (Carney et al, 1996:76). The researchers highlighted the urgent need to critically examine the decision making processes that provide the foundation for needs assessment in health visiting practice.

Lauri et al. (1997) endeavoured to describe the decision making processes used by 369 public health nurses working in Finland, Norway, Canada and USA and to explore any differences across these four countries. Building on the earlier work of Lauri and Salanterä (1995) they used the same 56 item Likert-type structured questionnaire developed for use in the earlier study, which the authors regarded as pilot work for this study. Findings show that the public health nurses working in different countries used different decision-making models and that the models varied considerably. Data analysis revealed five different decision-making models, which appeared to be informed by different decision-making perspectives. These included:

- *Processing rule-orientated decision making*
- *Systematic nurse-oriented decision making*
- *Processing client-orientated decision making*
- *Processing situation-oriented decision making*
- *Interpretive nurse-oriented decision making*. (Lauri et al, 1997:157)

Lauri et al. (1997) found statistically significant differences between the decision making of public health nurses working in the four countries. They concluded that the differences were a result of different health care contexts and systems and variety in nursing tasks.

In the late 1990's in the UK there have been an increasing number of studies examining issues around decision making in community nursing and this may reflect current policy initiatives addressing clinical effectiveness in health care practice. As part of a wider study evaluating nurse prescribing in eight demonstration sites in England, Luker at al. (1998) interviewed a sample of district nurses and health visitors who had successfully completed a nurse prescribing training course, about their decision making experiences in terms of prescribing. Semi-structured interviews were conducted with the nurses four times, at 3 monthly intervals following the implementation of nurse prescribing initiatives. Although not a primary aim of the research, the researchers sought nurses' views about:

> *the types of items to prescribe, whether to prescribe or recommend an over the counter purchases or whether to decline to prescribe at all.*
> (Luker et al, 1998:658)

In this study patients appeared to be a major influence on nurse prescribing, either because the nurse knew the patient well and was aware of the patient's medical history and financial status, or because the patient expected the nurse to write a prescription (Luker et al, 1998). Data also illustrated several examples of where nurses who prescribe pharmaceutical treatments encountered difficult decisions, particularly those situations where a patient's diagnosis was uncertain. Nurses generally felt more confident in making decisions when they had known the patient for a long time. In these situations nurses appeared to have more confidence because of their increased knowledge about the patient's medical history and appropriateness of treatments. The nurses were also more confident about prescribing items in areas where they were regarded as 'expert' e.g. practice nurses and district nurses were confident about prescribing items for wound care, but appeared worried about prescribing analgesics and laxatives (Luker et al, 1998). The authors suggest that this

is because most nurses base their practice on experiential rather than research based knowledge. Luker et al. (1998) point out that uncertainty can be a difficult issue for nurses to manage, but that this is part of being an accountable practitioner.

In a qualitative study in America, Watkins (1998) explored the decision making processes used by twenty-eight expert community health nurses selected through purposive sampling. The community nurses were asked to describe a critical incident from practice, where their judgement made a positive difference to a client's health outcome. Initially participants were asked to write a description of the critical incident, they were then asked five interview questions about the incident. Findings indicated that community health nurses adopt both rational and intuitive strategies during the process of decision making.

Data analysis revealed eight themes, the:

> *focus, type, and purpose of the decision making; characteristics of the decision maker; sequencing of events; data collection methods; facilitators and barriers to decision making; and nursing roles in the decision making process.* (Watkins, 1998:22).

Watkins (1998:31) found that these expert nurses "repeatedly described an assessment phase before problem identification or action specification." Disappointingly the paper provides limited detail about the methods and strategies used by the community nurses to gather patient data, stating only that the nurses listen[ed] to patients and their families, used visual observations and relied on "gut" feelings in determining if something was wrong with a client. Indeed Watkins (1998:31) found that "decision making is a subjective process" and that judgement is influenced by "the unique characteristics and specific circumstances of each decision-making situation." Intuitive decision-making processes, included not only "gut" feelings about something being wrong with a client but also "knowing the patient" (Watkins, 1998:30).

When making decisions nurses tended to take a holistic focus drawing on knowledge gained from previous education and experiences (Watkins, 1998). Interestingly Watkins (1998:31) found that nurses frequently described individuals in the clinical incidents "*as 'my patient' or 'my family', suggesting that once the nurse has been assigned to care for a specific patient, a sense of ownership and responsibility developed.*" Other factors found to enhance the decision making process included good communications with all involved in a client situation and sharing decision making with other professionals. Interestingly O'Sullivan (1999) also features this latter point in his framework for decision making in social work practice. Overall the findings from this study suggest that decision making is influenced by the subjective traits of the individual, however Watkins (1998) does not address the fact that the nurses own personality may influence decision making processes, neither is there any consideration of the client perspective. A limitation of this study lies in the fact that decision making was not examined in context, instead relying on the nurses self-reporting of critical incidents which could have been biased. Watkins (1998:31) also highlights another weakness of the study when she suggests that three of the four interview questions could be regarded as leading and may not have allowed the respondents enough freedom to express personal views about decision making.

In 1998 the only study to focus primarily on health visitor decision making was published by Lemmer et al. These researchers stated that there is "*no decision-making theory specific to health visiting*" and attempted to investigate the ways in which health visitors make and reach decisions (Lemmer et al, 1998:370). Lemmer et al. (1998:370) incorrectly suggest that no previous research has investigated "*the actual process of* [health visitor] *decision making*", focusing instead on "*the situations in which decisions must be made.*" They raise old, yet unresolved issues about the fact that measuring numbers of client contacts provides little information and undermines the complexity of health visitor professional judgements. Initially this study used a Delphi technique to construct a self-completion rating questionnaire (a repertory grid) to gather data from health visitors about their decision making characteristics (Lemmer, 1998). Unfortunately though, from the information presented in the paper

it is difficult to determine the numbers of health visitors involved, so only very tentative conclusions can be drawn from what is, in effect pilot work. The authors also indicate that they have undertaken some pilot interviews with health visitors but provide no further information about this.

Lemmer et al. (1998) suggest that experienced practitioners (in terms of number of years spent in health visiting practice) are more flexible in identifying potential solutions and adopt different mental processes in their decision making. They say that experienced practitioners are able to draw upon a personal body of knowledge and experience, which is not simply intuitive. Instead it "*is due to their ability to absorb the evidence presented by the case over time and to act upon it on the basis of their experience*" (Lemmer et al, 1998:369). These researchers believe that health visitors in the past have overestimated the impact of intuitive processes in decision making. They describe experienced practitioners as having an internal locus of control with "*increased psychological dimensionality in decision-making, denoted by decisions that anticipate outcomes*" (Lemmer et al, 1998:369). Unfortunately they provide no further evidence to support these jargonistic claims. Lemmer et al. (1998) suggest that less experienced health visitors rely instead on external data such as developmental assessments when making their decisions. The researchers also state that organisational issues such as GP attachment and professional guidelines can influence a practitioner's decision making.

Also in 1998 Offredy reported a very interesting study to examine the application of decision making concepts by nurse practitioners working in general practice settings in the UK. A snowball sample of 20 nurse practitioners participated in the study and observations of nurse practitioner consultations with clients were conducted. Semi-structured interviews were completed adopting a retrospective approach, to elicit detail about decisions regarding clinical diagnosis and management of patients. The author does however highlight the main limitation of this research strategy, that in using retrospective reports "*the retrieval operation is fallible, in that the cognitive processes used to perform the task may not be those accessed for explaining it*" (Offredy, 1998:999).

In this study Offredy (1998) examined the potential of four decision making strategies including decision analysis, the hypothetico-deductive method, pattern recognition and intuitive processes and how they could be applied to the reasoning strategies of nurse practitioners. Through a process of qualitative data analysis Offredy (1998:994) found that nurse practitioners' cognitive processes "*do not fit neatly into a single psychological approach to describe their decision making.*" Instead she found that nurse practitioners adopted different clinical reasoning strategies depending upon the particular client problem. Generally it was found that one model could be applied to each client situation, but sometimes intuition and pattern matching strategies merged.

Offredy (1998:992) states that:

> *the main difference between pattern matching and intuition is that intuition occurs at an unconscious level whereas pattern matching takes place at a conscious level.*

However, there is no discussion about whether or not the nurse practitioners were aware that they were adopting these reasoning strategies in practice. Furthermore, Buckingham and Adams (2000) have criticised Offredy's attempt to classify decision making processes suggesting that there are no fundamental differences between the examples she offers for pattern recognition and hypothetico-deduction. Also Offredy (1998) is sceptical about the usefulness of decision analysis techniques in situations other than those where diagnoses are required. She states:

> *the use of such a model is questionable when addressing management of symptoms and the importance of patients' action and feedback in the decisions making process. This is because many nursing problems are not so well structured.* (Offredy, 1998:998)

As earlier studies have found, data suggested that more experienced nurse practitioners would rely on their intuition when patients presented with uncertain problems. However these nurses also adopted a framework of "*presentation, examination and management*" in dealing with unfamiliar problems (Offredy, 1998:995). Experienced practitioners stated that:

> *'presentation' refers to the presenting problem and information acquisition; 'examination' refers to hypotheses generation and 'management' refers to how (and by whom) the problem will be managed.* (Offredy, 1998:995)

These nurses appeared to apply a framework to these uncertain problems which started with the nurse practitioner encouraging the patient to give her as much information as possible, combined with observation of non-verbal cues. This strategy then led to early hypothesis formation. The research also found that all nurses, whatever their level of experience adopted the hypothetico-deductive approaches to decision making. This study, like many others has also highlighted the importance of knowledge and prior experience in assisting decision making, with 65% of respondents stating that having prior experience of a situation facilitated their decisions (Offredy, 1998).

2.15 Conclusions from the literature

This chapter has examined the concept of professional judgement and has attempted to provide an overview of the relevant literature. A concept analysis of professional judgement has been conducted using an approach advocated by Morse (1995). This concept analysis has highlighted the potentially problematic and interrelated nature of the concepts of professional judgement, clinical reasoning, clinical judgement and decision making. The complexity of professional knowledge and its relationship to judgement and decision making has also been examined. Although the health visiting literature has many references to the term professional judgement there appears to be a paucity of research focusing specifically on 'professional judgement' in health visiting. In view of this, an attempt has been made to critically review research examining judgement and decision making in the wider field of community nursing practice.

Key themes emerging from this literature review include the fact that rational approaches to decision making research seem inappropriate for the study of health visiting practice, where the central focus of the work is not about the discovery of diagnoses but on health promotion work, often involving long term and ongoing assessment. Health visiting practice is influenced by a large number of constantly changing variables that cannot be effectively examined through rational theories of decision making. It would seem more appropriate to examine the complexity of health

visitor professional judgement by adopting an interpretive perspective. It is interesting to find that there have been no studies specifically investigating the nature of professional judgement or the processes by which professional judgments are made in either health visiting or the wider community nursing field.

Remarkably only five community nursing research studies have examined professional assessment and decision making by community nurses in real life contexts (Luker and Kenrick, 1992; McMurray, 1992; De La Cruz, 1994, Bergen et al, 1996 a and b; Offredy, 1998). This may well reflect the difficulties involved in studying practitioners in the client's home environment, yet it might also indicate the power of positivist and post-positivist philosophies in that researchers seem happy to continue to conduct research in pseudo-clinical situations despite apparent limitations. In the only study focussing purely on health visitor decision making, it is interesting to find Lemmer et al. (1998) indicating that clinical practice guidelines influence health visitor decision making. Yet no review of the impact of such guidelines on decision making processes has taken place.

Finally it seems extremely significant that despite greater consumer involvement being advocated in the UK National Health Service by the Department of Health (Dept. of Health, 1991; Dept. of Health, 1997; Dept. of Health, 1998b) only a small number of community nursing studies (e.g. Worth et al, 1995; Carney et al, 1996) have incorporated the client perspective in the study of needs assessment, judgement or decision making. This seems a rather startling situation in view of the current policy agenda that stresses the importance of providing a service which is both acceptable to the consumer and which reflects their expressed needs. In view of the current emphasis on clinical effectiveness in health care practice and the centrality of professional judgement to health visitors' practice, it seems highly pertinent to conduct a study to examine the nature of professional judgement in health visiting and investigate the processes by which judgements are made. Such a study is needed to continue to develop the knowledge base of health visiting practice by elucidating the components of health visitor professional judgement.

Chapter 3

A Preliminary National Study of Clinical Practice Guidelines

3.1 Introduction

This chapter will explore the use of guidelines in health visiting practice in the search for health needs and consider their potential impact on professional judgement. Its main focus is the practice guidelines which are issued to health visitors to assist in the identification and assessment of vulnerable families, with the intention of identifying 'health need' and increasing health visiting intervention and support to families. The chapter will initially examine the current NHS focus on 'evidence based practice' and the increasing moves towards clinical practice guideline development amongst health professionals and in particular in the health visiting service. The key policy initiatives that have influenced this move will be highlighted.

A national study will then be described which has attempted to evaluate the clinical practice guidelines issued to health visitors to assist in the identification of families requiring increased health visitor support and intervention. In a needs-led service this is an essential step to establish whether current practice guidelines are valid and potentially helpful to practitioners. This chapter offers one approach for analysing clinical practice guidelines and describes the critique and analysis tool developed for the study. The most important findings that have emerged from this preliminary research work will then be examined in the light of current health visiting practice and the wider study context.

3.2 Clinical practice guidelines

Over the last decade there has been a considerable interest in the development and use of clinical practice guidelines in medicine and nursing. However, confusion over

terminology often exists in the fact that the terms 'protocol', 'clinical practice guideline', 'local guideline' and 'health-care/nursing standards' are often used interchangeably in community nursing practice. Protocols and standards differ from clinical guidelines in that they are formal written procedures that address the management of patient/client care in specific situations. Standards are written in the form of "*an authoritative statement*" (Sullivan and Mann 1994:413), which should include an objective of care and detailed guidance on how to reach that objective (Duff et al, 1996).

Clinical guidelines however are:

> *systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.* (Field and Lohr, 1992:2)

A number of authors have recommended the need for clinical guidelines to be developed from sound research evidence combined with expert opinion (Grimshaw and Russell, 1993; Antrobus and Brown, 1996; Grimshaw and Eccles, 1998). Eddy (1990) has provided a useful distinction between standards and guidelines stating that standards describe appropriate health care and should be adhered to in all circumstances, whereas clinical guidelines while providing guidance to the practitioner, do allow flexibility and acknowledge professional discretion (Grimshaw and Russell, 1993). It is perhaps important to clarify that clinical practice guidelines should not be regarded as a replacement for professional judgement but that their purpose is to aid decision making processes (Sullivan and Mann, 1994; Carruthers, 1995). Where clinical practice guidelines are adapted for use by individual Community and Primary Care Trusts these are known as local guidelines and often contain more detailed operational specifications (Grimshaw and Russell, 1993; RCN, 1995).

In the UK NHS there is an increasing move towards developing clinical guidelines to improve standards of patient and client care (University of Leeds, 1994; Deighan and Hitch, 1995; Dept. of Health, 1998b). The current focus on 'evidence based medicine' and more recently 'evidence based healthcare' has recommended the need to develop

clinical practice guidelines based on evidence from randomised controlled research designs (Sackett and Rosenberg, 1995; Russell and Grimshaw, 1995). Evidence based practice is defined as:

> *the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based health care means integrating individual clinical expertise with the best available external, clinical evidence from systematic research.*
> (Sackett et al, 1996:71)

The overall purpose of evidence based clinical guidelines is to ensure that clinical practice is guided and underpinned by sound research evidence (Von Degenberg, 1996) and scientifically valid criteria.

Within nursing much emphasis has traditionally been placed on the development of practice standards, yet since the mid 1990's there has been considerable interest in the potential of clinical practice guidelines. Indeed, the International Council of Nurses (1996) has recommended that clinical practice guidelines should be regarded as one of the key ways of translating research evidence into practice. A consequence is that clinical guidelines are being introduced into many areas of nursing practice, for example, pressure sore prevention and management and treatment of leg ulcers. Clinical practice guidelines clearly have potential for providing guidance for patient/client assessment and health care interventions. However, what is particularly significant is the fact that very few research studies have been undertaken to evaluate the effectiveness of clinical practice guidelines in use in nursing practice (Royal College of Nursing, 1995).

The growth in clinical guidelines has been further stimulated by moves from the NHS Executive to recommend that guidelines should be used to inform commissioning (NHSME, 1993; NHSME, 1994). Antrobus and Brown (1996:39) again brought this issue into the spotlight by stating that:

> *rather than focusing purchasing procedures on levels of activity, health care commissioners should explore the possibility of purchasing guidelines and protocols.*

Some researchers have also outlined the possibility that clinical practice guidelines could reduce variations in clinical practices and promote more cost-effective care (Carruthers, 1995; Klazinga, 1995; Russell and Grimshaw, 1995). However, Hutchinson et al. (1995:50) are more cautious, highlighting that:

> *many clinical guidelines do not show an explicit link between the evidence on which they are based and the recommendations contained in the guidelines,* [and] *there are relatively few examples ... where guidelines have been shown to have a demonstrable and sustained positive effect on health care.*

Anecdotal evidence would suggest that a problem with many clinical guidelines being adopted for use in nursing practice is the fact that many are formed without sufficient empirical data, focusing instead on "*expert opinion*" (Russell and Grimshaw, 1995:78). Where clinical practice guidelines currently exist in nursing, the need to evaluate their quality seems a particularly pertinent issue, especially in view of clinical governance and policy initiatives which stress the potential of clinical guidelines for promoting clinical effectiveness and quality of client care (Dept. of Health, 1998b; NHSE, 1999).

3.3 Current issues in health visiting

Managers are continually faced with difficulties in making health visitor work practices explicit to commissioning agencies and the Government. Over recent years the health visiting service has been severely criticised for its universal approach and failure to target needs (Audit Commission, 1994; Roberts et al, 1996). To counteract this the use of clinical guidelines has been encouraged by a policy emphasis on specifying needs for which families are to be targeted (Audit Commission, 1994). A response to this has been the fact that many Community Trusts now issue health visiting staff with practice guidelines to assist them in identifying vulnerable families. Furthermore, in an attempt to reduce home visiting time by health visitors, visiting protocols, which prescribe the numbers of home visits and/or contacts for clients with children under school age, have been widely introduced (Carney et al, 1996). Clinical guidelines are viewed by many as the way forward despite few efforts to evaluate their effectiveness in practice. In view of the current interest around this topic it

seemed pertinent to undertake a study to assess the extent to which clinical guidelines are in existence to assist health visitors in identifying families requiring extra support and to examine their validity and reliability.

3.4 The study of practice guidelines

The study involved a national postal survey of the Senior Nurses of all 179 Community Trusts in England employing health visiting staff. The survey had two purposes. Firstly, to gather information about the existence of clinical guidelines to assist health visitors in identifying and prioritising families needing extra health visiting support. Secondly, copies of local Trust guidelines were requested from each Senior Nurse and the intention was to examine the documents in order to evaluate their validity and reliability. The overall aim of this preliminary work was to build up a national picture of the existence of such guidelines in England for the identification of vulnerable children and families requiring increased health visitor intervention and support.

A postal questionnaire was developed and distributed to all Community Trust Senior Nurses employing health visitors in November 1994. A complete list of Senior Nurses was obtained using an up-to-date NHS directory (Binley's Directory of NHS Management, 1994). This enabled the researcher to make direct contact with the sample population personally in writing. By targeting the total population of Senior Nurses, it was hoped to achieve a representative and unbiased sample. For this reason a number of strategies were employed to try and enhance uptake, as postal questionnaires can be problematic and are notorious for their low response rates (Scott, 1961; Moser and Kalton, 1971; Oppenheim, 1992; Polit and Hungler, 1999). The questionnaire was accompanied by a covering letter addressed to each Senior Nurse in person, detailing the nature of the research study, explaining selection and inviting participation in the project (See Appendix 3.1 – Copy of letter to Senior Nurses). Both Oppenheim (1992) and Newell (1993) have suggested that addressing envelopes and letters personally to the individual in question can help increase response rates. The questionnaire was conservative in appearance and a stamped addressed envelope was enclosed for ease of return.

The questionnaire designed for use in the study was a fairly short; two sided document and consisted of a combination of pre-coded closed questions and open questions/statements (See Appendix 3.2 for copy of the questionnaire). The questionnaire was planned so that straightforward 'tick response' closed questions could be answered first, before moving on to the more thought provoking open questions later. Six questions were included. The aim of the first three questions was to obtain general facts about the existence of guidelines in the Trusts for children in need of protection and for vulnerable families/children. Respondents were given the option of including a copy of the official guidelines currently in use in their area for identifying vulnerable families. The covering letter encouraged inclusion of these documents/policies. A closed question was included to determine the length of time that these guidelines had been in use. Question 4 asked whether the guidelines for identifying vulnerable families came into 'contracting' arrangements and respondents were encouraged to expand on this answer if they so wished.

Question 5 was an open statement asking respondents for their thoughts about and knowledge of any research underpinning the guidelines issued to health visitors. This statement was planned to encourage respondents to explore the area in some detail. It seemed a particularly important area to pursue in view of the fact that an earlier review of the literature (Appleton, 1994a) had indicated that the majority of research studies to date (by both health visitors and non-health visitors) have attempted to identify vulnerable families by using checklists or other screening tools, many of which are extremely dubious in their validity. The researcher was particularly interested to find out what research underpinned the guidelines. At the end of the questionnaire, respondents were asked to tick a box and attach their name and contact telephone number if they were interested in allowing the health visitors working in their Trust to participate further in the study. This question fulfilled the important function of providing access to a health visitor sample for the main study.

The chief advantage of using a postal questionnaire at this stage of the study was that it was a fairly cheap method for gathering data and required a lot less time and energy to administer than interviews. These were important considerations for the researcher

as the study formed the preliminary phase of a larger research project. It also enabled an extensive country wide sample to be targeted fairly easily. Other strategies were also used to improve response rates, for example responding promptly to all telephone calls and requests for information or duplicate questionnaires. Each questionnaire was also office coded so that non-respondents could be followed up. Scott (1961:164) argues, "*the use of follow-ups, or reminders, is certainly the most potent technique yet discovered for increasing the response rate.*" The covering letter also encouraged the Senior Nurse to include copies of local clinical guidelines and policies when returning their questionnaire response.

A log of returned questionnaires was maintained throughout data collection. Three sets of data were generated:

- The quantitative data generated through the closed ended questions/statements in the questionnaire were coded by hand then entered onto the statistical package Minitab (1991) and analysed descriptively.
- The qualitative data from the two open-ended questions on the questionnaire were analysed using a simple process of qualitative content analysis.
- The documents and guidelines for identifying and prioritising vulnerable families were critiqued as if they were research instruments in their own right. As no suitable tool was available to analyse the documents a critique and analysis instrument was developed for use in the study.

3.5 Using documents in a research study

Researchers often overlook the potential wealth of information that can be gathered from existing records and documents and many novice researchers fall into the trap of thinking that they must always set out to collect 'new' data. Indeed nursing records, protocols and clinical guidelines can provide community nurse researchers with easily accessible and readily available research data. Using this type of material in a study means that the documents are recorded as secondary data sources in the fact that they contain material "*not specifically gathered for the research question at hand*" (Stewart, 1984:11). This differs from primary research data where the researcher is responsible for the entire research process from the design of the project, to collection, analysis and discussion of the research data (Stewart, 1984).

The main advantages of using existing records/documents/clinical practice guidelines in a research study are that the data are readily available, take little time to collect and provide a relatively inexpensive form of data (Bailey, 1982; Treece and Treece, 1982; Webb et al, 1984; Lincoln and Guba, 1985; Polit and Hungler, 1999). This is often an important consideration for community nurse researchers who may have little time allocated for research purposes. A further strength of documentary evidence is its "non-reactivity" (Webb et al, 1984:114), the fact that records tend to be unbiased as the documents are collated usually for other purposes. The researcher is not in a position to bias subjects and the authors of documents are unlikely to assume their future use in research. Another advantage is the fact that the inquirer can obtain data without being 'present' in the field, this was demonstrated in the current study where documents were requested from Trust Senior Nurses through the use of the questionnaire.

The disadvantages of documentary data also need highlighting (Bailey, 1982; Treece and Treece, 1982; Stewart, 1984; Webb et al, 1984; While, 1987; Hakim, 1993; Appleton and Cowley, 1997). Documentary analysis is limited by the availability of material, missing or incomplete data, inaccuracies in material and inherent biases. Webb et al. (1984:114) identify the major sources of bias in documentary evidence when describing the two problems of "*selective survival*" and "*selective deposit.*" "*Selective survival*" (Webb, 1984:114) refers to missing or incomplete data, "*relevant data may be censored for confidentiality reasons*" (Hakim, 1993:136) or because their content may be perceived as reflecting badly on the institution/organisation (Webb et al, 1984). Selective deposit refers to the representativeness of the sample.

Further difficulties can arise with the analysis of documentary research data and were experienced in this study. Firstly the difficulties inherent in making a judgement that the documents sent by organisations reflect the total document and not just 'part' of an official document. Secondly, when analysing documents taken out of context information contained within them may lack the clarification from associated training sessions. Thirdly, documentary data, because it is presented in word form, usually requires a lot of preparatory work before analysis can take place. This problem is magnified when documents lack a standard format. Finally, an important limitation of

the study is the fact that documentary analysis can only focus on the existence and nature of guidelines as reported by Senior Nurses and no accurate assumptions can be made about health visitors' adherence to the guidelines in practice.

3.6 The critique and analysis tool

A number of researchers have highlighted the difficulties associated with content analysis of documents and particularly the coding difficulties encountered when faced with a large number of documents which lack any standard format (Treece and Treece, 1982; Guba and Lincoln, 1981; Bailey, 1982; Hakim, 1993). As no suitable tool was available a critique and analysis tool was developed to examine the seventy-seven documents sent to the researcher. For the purpose of the analysis each document has been regarded as a 'research instrument'. The critique tool developed was informed by a number of texts but has been adapted primarily from the work of Treece and Treece (1982), Guba and Lincoln (1981) and Bailey (1982). The focus of the critique tool was to determine the nature of each document and to examine whether the document can stand up to simple tests of reliability and validity, it took into consideration the reasons for the researcher undertaking this documentary analysis:

- to evaluate existing documents to describe their nature and content
- to consider what underlying assumptions the documents make about the nature of 'vulnerability' and families requiring increased health visitor support
- to analyse the indices/concepts/risk factors represented in the documents, to examine how far they are supported by research evidence
- to consider how well supported by research are the approaches that health visitors have taken to identify vulnerable families
- to consider whether the clinical guidelines are intended as an aid to or replacement for professional judgement.

The document analysis and critique tool developed for use in the study was based on a 'checklist' of 38 questions/statements to be applied to each of the seventy-seven documents (Appendix 3.3 – Critique and analysis tool for documents). These questions were split into five separate parts within the critique tool:

Part A – Authorship and body

The aim of Part A was to obtain a broad overview of the nature of each document/research instrument. Each document was logged according to its office code number (Statement 1). This section of the critique tool focuses mainly on "*authorship – who conceived the material*" and "*body – the form on which the data are found*" (Treece and Treece, 1982:268). Questions were raised about whether any instructions accompany the guidelines/document as this could influence reliability. One question focused on how and where assessment data is recorded by health visitors using the instrument.

Part B – Family vulnerability

The second section of the critique and analysis tool centred on the concept of 'vulnerability' and increased support offered to vulnerable families by health visitors. The five questions in this section concentrated on the stated "*function - the purpose or reason*" (Treece and Treece, 1982:268) for the guidelines. Question 12 explored what underlying assumptions are made about 'vulnerability' and families seen to be requiring increased health visitor support. In view of previous research findings (Appleton, 1994b) it appeared important to determine whether or not the guidelines recognise vulnerability as a complex, ambiguous and transient concept. Exploring whether family vulnerability and hence increased health visitor support is linked with child protection was also addressed. This was because an earlier review of the literature (Appleton, 1994a) indicated that the majority of studies in which health visitors have been involved in making assessments of vulnerable families have tended to focus on the use of screening procedures for identifying families 'at risk' of child abuse.

Part C – Professional judgement

This section considered professional judgement and decision making skills. Questions in this section were planned to elicit detail about the relationship between official guidelines and professional judgements. This appeared highly pertinent in view of the fact that a recent review of the literature revealed that the majority of research studies in which health visitors have been involved in making assessments of vulnerable families include the use of checklists/screening tools and not an evaluation of the health

visitors' own assessment processes. Research evidence would also suggest that health visitors rely on their own professional judgements, rather than guidance from official guidelines in the assessment of vulnerable families (Appleton, 1993; Williams, 1997).

Part D – Reliability and validity

This section of the critique and analysis tool concentrated on the research basis of the guidelines. Initial questions focused on the reliability of the documents and "*the extent to which a measure gives consistent results*" (Nolan and Behi, 1995a:472). Three aspects of reliability are usually explored when studying the reliability of a measuring instrument; these are internal consistency, stability and equivalence. Internal consistency "*the extent to which all the instruments subparts or items are measuring the same attribute*" (Polit and Hungler, 1999:433) was considered first in the critique tool. To estimate internal consistency the researcher had to consider whether all the indices on the instrument were in fact measuring the same concept. It was therefore important to consider how clearly detailed and defined were the indices within the documents and to consider how they had been sampled.

The stability of a measure "*refers to the extent to which the same results are obtained on repeated administrations of the instrument. Estimation of reliability here focuses on the instrument's susceptibility to extraneous factors from one administration to the next.*" (Polit and Hungler, 1999:412)

The researcher felt it was inappropriate to consider the 'stability' of the documents sent as no test/retest measurement facility existed. However, it is likely that fluctuations in measurement will occur over a period of time because of the nature of what is being measured i.e. the need for families to receive increased health visitor support. For this reason alone instruments are likely to have low reliability.

The third aspect of reliability that was considered in relation to the documents is 'equivalence'. 'Equivalence' is the extent to which different health visitors using the same instrument applied to the same individual/family at the same time, or when two parallel instruments are applied to the same individual/family at the same time, obtain consistent results (Reardon Castles, 1987; Polit and Hungler, 1999). This is

commonly known as inter-rater reliability. In terms of the equivalence of the health visitor documents, the researcher considered whether the documents provided evidence of the following factors: - training for users of the instrument, competency and ability of the health visitors, inconsistencies between health visitors using the instrument, health visitor bias and standardised measurement scale to reduce the risk of bias. However, it is important to recognise that just because a document did not actually mention training for users of the instrument, this does not mean that it does not happen in practice. This illustrates one of the disadvantages highlighted earlier of 'incomplete data' which can be problematic when analysing documents.

Evidence of validity was also considered in this section of the critique tool. Validity is "*the degree to which an instrument measures what it is intended to measure*" (Polit and Hungler, 1999:717). The validity of a measure is usually considered in terms of: (i) face validity, (ii) content validity, (iii) criterion-related validity which is differentiated as (a) concurrent validity and (b) predictive validity and (iv) construct validity (Bowling, 1991; Polit and Hungler, 1999; LoBiondo-Wood and Haber, 1994; Nolan and Behi, 1995b).

Face validity is the weakest form of validity and is usually regarded as a highly subjective measure (Reardon Castles, 1987; Treece and Treece, 1982). Within the critique tool face validity was addressed by critically examining each document and considering whether all the items included dealt with vulnerability and appeared to measure families requiring increased support from health visitors. To estimate content validity the researcher considered whether the content of the documents had been judged to be appropriate for the purposes of the document (Treece and Treece, 1982; Gibbon, 1995). This might be the case if a literature review has been undertaken which informs and supports its content. Pilot work may have been completed to assess the representativeness of the document's content, or a group of experts may have been consulted about items included within a document, particularly the risk indices incorporated in an official guideline (Burns and Grove, 1997; Treece and Treece, 1982).

It was not feasible to address criterion-related validity when analysing the documents. This is because both concurrent and predictive validity involve the measure being

correlated with some external criterion [standard/instrument], which has already been judged to be valid (Powers and Knapp, 1990). The researcher is not aware of any clinical guideline issued to health visitors to assist in the identification of families requiring increased support, which has been proven to be truly valid and reliable.

Construct validity refers '*to the validity of the theory behind the* [measure]" (Herbert, 1990:53) and is considered to be the most important aspect of validity. Construct validity in relation to the documents is concerned with the extent to which the results of applying the documents reflect the underlying theoretical concepts, the vulnerability indices. This would be "*the extent to which the theoretical concepts have been successfully operationalised*" (Herbert, 1990;17). In terms of the vulnerability indices the researcher considered whether they were accepted measures, whether or not the indices are robust and valid concepts and what research evidence supports this. Questions were also raised regarding how the concepts are detailed and defined, this is important to ensure that the same meaning is shared by health visitors in order to reduce the risk of bias.

Part E – Risk factors / risk indices

The final section of the critique tool listed and coded all risk factors/indices referred to in each document.

3.7 Analysing the documentary data

Having developed the critique and analysis tool for the documents, a computer data base was established using Microsoft Excel. Reviewing each document and registering information on the data base was a time consuming and laborious process. However, consolidating the documentary data on Microsoft Excel enabled pertinent issues to be explored more easily, which is particularly important when dealing with documents of different formats and lengths.

The qualitative documentary data (Questions 2 - 37) were analysed question by question separately for words, descriptions and recurrent categories. Diagrams were then constructed to illustrate in visual form how the categories linked together. The data were continually compared with the associated questionnaire data. The listed risk

factors/indices (Question 38) were analysed using a simple quantitative enumeration approach, which was helpful in illustrating the range of risk factors contained in the documents, exploring the frequency with which they were cited and examining the research evidence supporting their use in the guidelines.

3.8 Findings

Throughout the data collection stage the researcher maintained a log of returned questionnaires. Follow-up letters were sent to non-respondents as detailed in Table 3.1 (See Appendix 3.4 – Copy of follow-up letter). Following a three month period of data collection the exploratory questionnaire resulted in a response rate of eighty-seven percent (156 Senior Nurses). There was clearly much interest in the topic and this was further supported by the fact that nearly 60% of areas were willing to allow health visitors in their Trust to participate further in the study.

Table 3.1: Timetable of events/follow-up

Date	No. questionnaires distributed	No. questionnaires received	% received	% total
W/C 14.11.94	179*	94	52 %	94 52 %
W/C 2.1.95	87	23	13 %	117 65 %
W/C 7.2.95	46	39	22 %	156 87 %

* Originally 195 questionnaires were distributed to Trust Chief Nurses but of these 16 stated that they did not employ health visitors so were excluded from the study as not matching the sampling criteria.

Table 3.2 illustrates the numbers of Trusts having official guidelines to assist health visitors in identifying families requiring extra health visiting intervention. (This is apart from families where there are currently children on the child protection register). The findings illustrate that clinical guidelines are widely available in 98 (63.2%) Community Trusts in England to assist health visitors in identifying and prioritising vulnerable families. Of the areas not issuing official guidelines to health visitors, eleven areas reported to be in the process of developing guidelines. It is also possible that other areas were considering developing guidelines, but did not actually record this on the questionnaire.

Table 3.2: Community Trusts having official guidelines to assist health visitors in identifying families requiring extra health visiting support.

Guidelines to identify families requiring extra support	No. of Trusts (n = 155)*	% of Trusts
Guidelines	98	63.2 %
No Guidelines	57	36.8 %

* 1 = No answer

3.9 The nature of existing guidelines

Of the 98 (63.2 %) Senior Nurses stating that their Trusts had official guidelines to assist health visitors in identifying and prioritising vulnerable families, sixty-seven (68.37 %) areas enclosed a copy of the guidelines. Surprisingly eight Trusts sent copies of two different types of guidelines that they distribute to staff and one area sent three. Indeed a total of 77 separate guidelines were sent to the researcher from 67 Community Trusts, this obviously raises questions about the purpose of these guidelines.

The seventy-seven documents sent varied markedly, they were quite different in terms of content, format and length. The majority of guidelines were presented on A3 or A4 sheets/booklets and ranged from one to eighteen pages in length. Seventy-eight (79.59%) of the 98 Trusts stating that they issued guidelines to health visitors had introduced them within the last five years. Sixty-two (80.52%) of the seventy-seven documents sent to the researcher had instructions accompanying the guidelines, of these, 26 (33.77%) sets of instructions were fairly vague or minimal. To illustrate the range of guidelines sent, the guidelines were categorised according to the nature of their content. See Table 3.3.

Table 3.3: The range and numbers of guidelines sent to the researcher.

Classification of guidelines	No. of guidelines (n = 77)	% of guidelines
Professional judgement only	2	2.60 %
List of risk factors/risk indices	19	24.68 %
List or map of risk factors/risk indices and professional judgement	9	11.69 %
Vulnerability standard	1	1.30 %
Child protection guideline/standard	3	3.90 %
Vulnerability checklist/screening tool and/or scoring system	35	45.45 %
Family health assessment including risk indices or a scoring tool	5	6.49 %
Cause for concern guidelines where focus is professional judgement and identifying dangers to families	2	2.60 %
Aide memoire for risk assessment. Questions to structure professional thinking	1	1.30 %

3.10 Classification of guidelines

The fact that no standardised guideline is used throughout the country is in itself a significant fact and may reflect the ambiguity surrounding the term vulnerability and families requiring increased support. It could also exacerbate the difficulties which health visitors face in articulating how they make family assessments. Classification of the guidelines was as follows.

Professional judgement

These guidelines focus on basic packages of care to be provided by the health visiting service. They detail expectations for minimum service provision. Health visitors are to use their own professional judgements to identify and prioritise vulnerable families and children requiring increased intervention and support.

List of risk factors/ risk indices

These guidelines consist purely of lists of risk factors/risk indices. Many are subdivided into sections focusing on parents/carers, child(ren), family circumstances and social circumstances etc. Nearly one quarter (24.68%) of the guidelines sent to the researcher were classified in this category. Interestingly many of these lists focus

on common risk factors found in child abuse cases. This point is illustrated in the following extracts taken from some of the guidelines.

> *Certain family and social characteristics have been frequently found in cases of child abuse* (Q. 674)
>
> *Common family characteristics in child abuse* (Q. 530)
>
> *Factors which contribute to child abuse* (Q. 601)

These examples obviously raise questions about the extent to which 'vulnerability' is linked in respondent's minds with child protection.

List or map of risk factors/risk indices and professional judgement

These guidelines include lists or maps of risk indices which health visitors are to use as a guide in formulating their own professional judgements about a family needing increased support. These guidelines appear to be trigger lists, which could enhance decision-making, but certainly do not override professional judgement. They could be used to assist health visitors in articulating why they feel concerned about certain family situations. Many of these guidelines encourage health visitors to discuss families needing extra support with their manager/child protection nurse specialist/nurse advisor.

Vulnerability standard

Consists of a standard statement, including structure, process, outcome sections, about health visitors' responsibility towards vulnerable groups and individuals. The standard does not give health visitors any clues in how to go about identifying a family needing increased health visiting intervention, instead assessment processes are implicit.

Child protection guidelines or standard

Guidelines or protocols for staff involved with child protection issues. The guidelines included in this category focus purely on child protection issues, as opposed to guidelines for identifying vulnerable families requiring increased health visitor support. One guideline consisted of a single standard statement about the need for

staff to be aware of current child protection policies and procedures, whilst another included a protocol for staff involved in child protection, including report writing. The third area stated that they did not have any official guidelines to assist health visitors in identifying vulnerable families, but were in the process of developing one, however, they did enclose a copy of the procedures and guidance issued to staff in cases of suspicion of or actual child abuse. Arguably these guidelines do not fall into the particular focus of this study.

Vulnerability checklist, screening tool and/or scoring system

These guidelines focus on the use of checklists, scoring systems, and/or screening tools to make assessments of children and their families as high or low risk for child abuse and neglect. The aim of this risk strategy is "*to give special attention* [in this case increased health visitor intervention] *to those in greatest need of help in parenting before child maltreatment occurs*" (Browne and Saqi, 1988:58). The majority of guidelines - thirty-five (45.45%), were classified in this category. These guidelines appear to be heavily influenced by the scoring approaches of non-health visitors used in the screening of risk assessment. A major criticism of these sorts of checklists/screening tools is that professional judgement does not appear to be recognised. This was clearly identified in an earlier study when health visitors were identifying 'other' vulnerable families who did not fit into the Trust's criteria of vulnerable families (Appleton, 1993). By focussing on checklists and screening tools the value of professional judgement appears to have been unrecognised or even disregarded (Barker, 1996).

However on closer examination it was interesting to find that 21 of these 35 (60%) guidelines do recognise professional judgement to some extent. For example, guidelines 231 and 623 both refer to "*Imponderables (Gut feeling)*", guideline 406 to "*Families who make one feel instinctively uneasy*" and guideline 450 to "*Any other factor which makes Health Visitor instinctively uneasy*".

Family Health Assessment

These guidelines consist of a family health assessment form to be completed by a health visitor in conjunction with a client to determine the family's health needs. The aim of the family health assessment is to identify factors that could indicate that a family needs extra health visiting support. Interestingly four of the five family health assessment forms were composed of risk indices and the fifth consisted of a scoring tool.

'Cause for concern' guidelines

Here the focus is on professional judgement regarding the assessment of hazards/dangers to families. These guidelines encourage health visitors to record in writing concern factors about children and families, one of the guidelines also noted recording family 'strengths'. These types of guidelines provide minimal information for health visitors and the focus appears to be on the use of professional judgement to prioritise whether families require increased input from the service.

Aide memoire for risk assessment

This guideline consists of ten questions to structure professional thinking and determine professional judgement. The guideline is to be used in conjunction with an aide memoire of risk indices to help to determine the level of support a family needs.

Discussion

Over half of the guidelines sent to the researcher were presented as formal protocols, this appears to reflect an earlier NHS Executive recommendation to develop guidelines to rationalise service provision (Deighan and Hitch, 1995). It is worth considering the fact that some of these guidelines may not in fact assist practitioners to assess family health needs at all. Instead, what they do is provide a classification system of families' needs, ranging from a state of high dependency or vulnerability to one of low dependency/vulnerability. Yet this sort of classification can only take place once a practitioner has made a professional judgement that a family is vulnerable. They do not help to explicate the assessment process at all. If anything, they have the potential to undermine professional skills and judgements. A further dilemma surrounds the potential mismatch between a health visitor's professional judgement and a Trust's official guideline, which could result in conflicts for practitioners.

3.11 The reliability of guidelines

Each guideline was critically examined to determine evidence of validity and reliability. Overall the guidelines provided little evidence of reliability. There was a lack of structured assessment formats, which could reduce the risk of user bias and many of the risk indices identified in the guidelines were fairly subjective in nature and not well defined. Several respondents highlighted this level of subjectivity, for example Q. 489 who stated:

> *The reliance on professional opinion/summary of concerns allows a different emphasis to be placed on each of the specific aspects of the assessment.*

3.12 The maze of risk indices

It can be seen from Table 3.4 that many of the guidelines included risk factors/risk indices in some form. When all the various indices/risk factors were collated, there were 133 different types mentioned in the documents, many of which were not supported by sound research evidence. The eleven most frequently cited risk indices are highlighted in Table 3.4.

Table 3.4: The most frequently cited risk indices

Risk Factors / Indices	Frequency
Mental health problems	60
Chronic illness or birth defect or development lag	56
Unrealistic expectations of child and generally negative attitude to child	49
Abuses alcohol and/or drugs	49
Chronic illness/health problems	48
Social/economic problems	48
Sub-standard living conditions	45
Poor extended family relationships /isolation	44
Poor parenting affecting child's health	44
Known to be violent and/or suicidal	41
Below 20 (or other specified age) at birth of first child	41

The documents provided little evidence of internal consistency for 55 (80.88 %) of the 68 guidelines which included risk factors or listed indices in some form, indices were included which were not defined in detail. For example, most indices are only

one or a few words long – Q. 457 refers to "*single parents*" and "*poverty*", Q. 917 "*Birth trauma*" and "*poor housing*" and Q. 764 "*parenting skills*", "*medical*" and "*social*". These terms are all open to varied interpretations by different health visitors; their vagueness and lack of specificity reduce the reliability of the measuring instruments. The majority of Community Trusts 62 (80.52 %) gave no indication of how the content of the guidelines had been sampled. Over two thirds of the guidelines 55 (71.43 %) provided no evidence of equivalence, giving no information about training for users of the instrument, competency and ability of the health visitors, inconsistencies between health visitors using the instrument and health visitor bias.

Reliability was addressed in a small number of guidelines where the health visitor was encouraged to discuss a family, which was causing them concern with a nurse advisor/manager and where staff using the guideline undertook an associated training session.

3.13 The validity of guidelines

Within the critique tool, face validity was addressed by critically reviewing each document and considering whether all the items included dealt with vulnerability and appeared to measure families requiring increased support from health visitors. The majority 54 (79.41 %) of the 68 guidelines that included risk indices in some form gave equal weighting to all risk indices. So in Guideline 317 "*unusual forename*" was given an equal weighting as "*previous history of family violence or child abuse.*" A number of guidelines clearly did not recognise that family vulnerability could be the result of multiple interacting factors, with some guidelines focusing solely on certain aspects, such as the child or parent/carer, with none of the suggested indices focusing on wider social, cultural, environmental or emotional issues as recommended in the recently published 'Framework for the Assessment of Children in Need and their Families' (Dept. of Health, 2000)

Content validity was assessed by determining whether the content of the documents had been judged to be appropriate for the purposes of the guideline (Treece and Treece, 1982; Gibbon, 1995). Grimshaw and Russell (1993) have stressed the

importance of assessing the validity of a clinical guideline by determining whether there is evidence of a formal systematic literature review having been completed. However, only 8 (8.16%) respondents described having undertaken a literature review and questions can be raised about the effectiveness of these reviews. Indeed an in-depth review would have determined that although a number of research studies have focused on risk assessment in terms of child protection, many of the tools/guidelines used in previous health visiting studies lacked validity and/or have not been evaluated properly (Hills et al, 1980; Woods, 1981; Fort, 1986; Walker and Crapper, 1995; Browne, 1995).

3.14 Guidelines and Commissioning

In view of the ongoing government emphasis on a more effective and efficient use of existing NHS resources, it appeared important to consider whether and how managers were marketing health visiting services with vulnerable families. Two NHS Executive documents have recommended that guidelines should be used to "*inform contracts*" (NHSME, 1993; NHSE, 1994). Thus, respondents were asked whether 'vulnerability' guidelines enter into contracting arrangements between purchasers and providers. Currently, only a small number of Community Trusts 35 (35.71%) include the clinical practice guidelines to assist health visitors in identifying vulnerable families in service contracts. However, many areas were addressing this issue and considering the need to include guidelines in future contracts. It is worrying that this is the case when the majority appear to lack validity and reliability. A problem with rigid adherence to clinical guidelines is that vulnerable families could be missed and important preventive work might not be undertaken.

3.15 The research basis of guidelines

Of the 98 Community Trusts having guidelines to assist health visitors in identifying and prioritising families requiring extra support, only 19 (19.39 %) respondents who stated that the guidelines were based on published research, were able to refer to a published study. The majority of research studies 17 (89.47 %) to which respondents referred are studies related to screening for potential child abuse. This indicates that

there appears to be a strong link between child protection and the respondents' perceptions of guidelines to assist health visitors in making assessments of families needing extra intervention. This is further supported by the fact that the documentary analysis also revealed that in 33 (42.86 %) cases, the documents issued to health visitors to assist them in identifying vulnerable families were closely linked to child protection.

Eleven comments were made about studies not focussing on child protection, this could indicate a recognition by some Community Trusts that families may be 'vulnerable' and in need of increased health visitor support for reasons other than child protection concerns. Of the eleven, four (36.36 %) referred to SIDS/CONI research and three (27.27 %) to the Edinburgh Post Natal Depression research. Both schemes are closely linked with increased support from the health visiting service.

Interestingly the majority of questionnaire respondents attempted to discuss research in a non-specific and rather vague manner. Optimistically this could mean that there is a research basis to the guidelines but that the respondents are not able to articulate it. However, the present situation appeared to be summed up by one respondent who stated:

> *The vulnerability indices ...enclosed have been gobbled* [sic] *together to at least give health visitors a means of making some decisions. They are warned that they are indices only and not entirely infallible.* (Q. 734)

Overall, the research evidence supporting the use of guidelines to assist health visitors in identifying and prioritising families is minimal. Furthermore, the fact that many of the documents sent to the researcher are not based on systematic research reviews raises the question of whether they should really be regarded as 'clinical practice guidelines' at all (Grimshaw and Russell, 1993; Nuffield Institute for Health, 1994). Perhaps 'formal guideline' is a more accurate description for these types of documents.

3.16 Professional Judgement and Practice Implications

Despite the wide variation in guidelines sent to the researcher, it was interesting to find that professional judgement was recognised in 33 (42.86 %) of the guidelines to some extent and appeared implicit in another 20 (25.97 %). Thus a total of 53 (68.83 %)

guidelines recognised the importance of professional judgement to some extent. Evidently further research is needed to explore professional judgement in health visiting, particularly in terms of identifying families needing increased interventions. There are clearly a number of pertinent issues: -

To what extent do assessment guidelines and visiting protocols direct health visitors' in making assessments of family health needs?

Do health visitors make their own clinical assessments of families needing extra support or do they have a checklist at the back of their mind or a guideline to refer to?

Are newly qualified staff more likely to make use of official guidelines than more experienced staff?

Does the use of checklists and guidelines constrain professional judgement?

If health visitors are using their professional judgements to make family assessments (and within many guidelines professional judgement could stand alone) this raises the important issue of whether health visitors should be exerting influence on managers not to rely on dubious checklists/guidelines. Furthermore, senior nurses in fifty-seven (36.8 %) Community Trusts stated that no clinical guidelines were issued to health visitors and one would assume that in these areas practitioners are relying on their own professional judgements when making family assessments. This raises the important question of whether these professional judgements could in fact be valid but have just not been proven. Indeed an earlier study indicated that a large proportion of health visitors were using their own professional judgements in identifying families needing extra input despite the presence of official guidelines and for many health visitors gut feeling/instinct was a significant factor in the assessment process (Appleton, 1995). There is clearly a need for professional judgement in health visiting practice to be explored further and the processes involved detailed and examined. This is an essential step in developing a validated 'health visiting assessment process', which can be formally utilised in practice and used as a tool in health visitor education.

3.17 Summary

Documentary evidence can provide the researcher with a wealth of rich and detailed data which is unbiased by the data collection process. This chapter has described the processes undertaken when developing a method for the data analysis of clinical guidelines used in health visiting practice to identify families needing increased support. In view of the concerns raised by the RCN (1995) and Hutchinson et al. (1995) about clinical guidelines it is essential that health visitors start to consider the validity and relevance of clinical practice guidelines used in health visiting practice. Practitioners need to consider whether the use of such guidelines could constrain professional practice and examine the legal and ethical implications surrounding their use. It is also important to question whether it is ever appropriate to attempt to replace professional judgement as suggested by the shift towards the greater use of clinical guidelines in contract specifications.

The documentary analysis method described in this chapter has revealed evidence that formal, but generally subjective and invalid guidelines are widely in existence throughout the country, for identifying families with increased health/social needs. It is also worrying that many Trusts are considering the inclusion of such guidelines in service contracts when the majority appear to lack rigor. A problem with rigid adherence to clinical practice guidelines is that vulnerable families could be missed and important preventive work not be undertaken. Maybe it is time for health visitors and their managers to heed the warning of Grimshaw and Russell (1993:245) who state:

> *if those developing guidelines fail to overcome the many potential biases inherent in that development, the resulting guidelines may recommend ineffective or even dangerous clinical practice.*

To conclude, this preliminary work has outlined the fact that despite the widespread existence of clinical practice guidelines in health visiting practice, it appears that professional judgement is recognised as a potentially significant element in the professional assessment of family health needs. It therefore seemed timely to conduct a research study to uncover the factors that may influence a health visitor in making a judgement to offer a family increased support and to begin to unpack the processes

involved in assessing family health needs. Such a study is needed to explicate the health visiting judgement process and to explore the relative impact of professional knowledge, intuitive processes and formal guidelines in the assessment of family health need (Appleton, 1997a).

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Chapter 4

Constructivism a Theoretical Perspective for the Study of Health Visitor Professional Judgement

4.1 Introduction

This chapter will begin by outlining the aims and objectives of the main study conducted to examine health visitors' professional judgements and use of formal guidelines in identifying families requiring extra health visiting support. The chapter will explore the philosophical underpinnings of the main study through an analytical discussion of the constructivist research paradigm. It will present a description of the researcher's journey through a contemplation of the philosophical origins of constructivism, contrasting it with the dominant paradigm in evidence based practice. This is essential to explain why constructivism offers an appropriate foundation for the case study research strategy adopted in the inquiry, which will be explored further in Chapter 5. The chapter will conclude by explaining the suitability of this philosophical approach in the detailed examination of health visiting practice.

4.2 Study aim and objectives

As the preliminary research work has progressed, the focus and objectives of the main study have been further refined and clarified. Indeed in view of the findings of the early research work, the evolutionary nature of the inquiry is illustrated in the fact that the term 'clinical practice guideline' will be replaced by the phrase 'formal guideline', which more accurately reflects the guidelines existing in current practice contexts. Thus the overall aim of the study is to examine health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support.

4.3 Objectives

Four key objectives of the study were identified:

1 To observe and examine how health visitors make assessments in their day to day professional practice.

2 To explore health visitors' professional judgement in identifying health needs and prioritising families requiring extra health visiting support.

3 To consider how checklists/guidelines and professional judgement contribute, if at all, to the process of targeting health needs and the allocation of resources.

4 To examine clients' perceptions about the effectiveness of health visitor interventions in identifying and addressing their health needs.

4.4 Theoretical paradigms and perspectives

A paradigm is a "*basic belief system or world view that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways*" (Guba and Lincoln, 1994:104). These paradigms or belief systems define the limits of any research inquiry process. They provide a model for how an inquiry should be conducted.

In 1994 Guba and Lincoln acknowledged four competing paradigms of research inquiry: positivism, post-positivism, critical theory and constructivism, adding in 2000 a fifth, the participatory paradigm (Lincoln and Guba, 2000). Each have their own set of philosophical assumptions and offer inquirers different ways of looking at and understanding the nature of the social world.

Guba (1990) states that all paradigms can be classified by a basic set of assumptions and beliefs, which correspond to the responses to three philosophical questions:

> **The ontological question:** "What is the nature of the "knowable" ? Or, what is the nature of "reality" ?" Guba (1990:18). Ontological questions explore the nature of social reality and what can be known about it (Appleton and King, 1997).
>
> **The epistemological question:** "What is the nature of the relationship between the knower (the inquirer) and the known (or knowable) ?" (Guba, 1990:18).
>
> **The methodological question:** "How should the inquirer go about finding out knowledge ?" (Guba, 1990:18). Methodology is concerned with the process of gathering knowledge about what exists in the world (Porter, 1996) in order to answer the research question.

Depending on the particular philosophical stance taken by the researcher, there are clearly many different ways in which the above questions may be answered. Thus the particular paradigm selected will influence the methodology a researcher chooses to use.

4.5 The beliefs of constructivism – Philosophical underpinnings

Constructivism is one of the more recent paradigms which has emerged to challenge positivism and post-positivism and has developed primarily through the works of Egon Guba and Yvonne Lincoln (Guba, 1990; Guba and Lincoln, 1981, 1982, 1989, 1994; Lincoln and Guba, 1985). Whilst acknowledging the technical achievements of the positivist paradigm, they recognise the limitations of applying an empirical scientific method to the study of human behaviour and events (Lincoln and Guba, 1985). As Stringer (1996:6) notes:

> *the objective and generalisable knowledge* [sought in positivism] ... *often is irrelevant to the conflicts that practitioners encounter, or has little impact on the difficulties they face.*

Constructivists seek to undertake research in natural settings. This mode of inquiry offers an opportunity to examine in detail and begin to understand people's views about the nature of the social world. Originally this theoretical perspective was termed the "*naturalistic*" paradigm (Guba and Lincoln, 1981, 1982; Lincoln and

Guba, 1985) more recently it has become known as the "*constructivist*" paradigm (Guba and Lincoln, 1989, 1994). Guba and Lincoln (1989:19) decided to adopt the term "*constructivism*" as this encompasses the central feature of the paradigm that is "*its ontological assumption that realities, certainly social/behavioural realities are mental constructions*".

Currently there is a paucity of literature examining the potential for constructivist inquiry in community nursing research. There is also confusion over terminology when the word constructivism is wrongly linked with constructionism (Appleton and King, 1997). Social constructionism has its origins in sociology and is concerned with the "*processes by which human abilities, experiences, common sense and scientific knowledge are both produced in, and reproduce, human communities*" (Shotter and Gergen, 1994:i). Unlike constructivism, it holds the view that understanding is not constructed by the individual but shaped purely by collective endeavours and social processes (Schwandt, 1994; Potter, 1996). Furthermore, it "*seeks to relate knowledge to* [people's] *social background and group allegiances*" (Potter, 1996:128).

Interestingly Guba and Lincoln (1989; 1994) have continued to avoid providing any clear definition for the term constructivism and this can cause difficulties for researchers. Stake (1995:170) however defines constructivism as the "*belief that knowledge is made up largely of social interpretations rather than awareness of an external reality.*" With the implication that "*knowledge is constructed rather than discovered*" (Stake, 1995:99). Meanwhile, Guba and Lincoln (1994) rather than offering a clear definition, continue to discuss constructivism by exploring the three philosophical questions highlighted earlier and by describing five principles (Lincoln and Guba, 1985) which will be examined in due course.

This approach to research aims to understand the variety of constructions which people possess, trying to achieve some consensus of meaning, but always being alert to new explanations with the benefit of experience and further information (Guba and Lincoln, 1994). Schwandt (1994:118) states that the purpose of constructivism is to understand "*the complex world of lived experience from the point of view of those who*

live it." These constructions endeavour to help people explain and make sense of their experiences (Schwandt, 1994). Stringer (1996:41) describes constructions as "*created realities*" and "*sense-making representations*." Guba and Lincoln (1994:113) suggest that as time passes both participant and researcher constructions become "*more informed and sophisticated*". Therefore the goals of constructivism, "*understanding and reconstruction*" (Guba and Lincoln, 1994:113) of people's experiences, differ markedly from those of positivism and post-positivism where explanations are sought in an attempt to predict and control phenomena.

Furthermore, constructivists believe that people give meaning to reality, events and phenomena through sustained and "*complex processes of social interaction*" (Schwandt, 1994:118). It is only by interpreting the world of meaning that one can begin to understand it. The inquirer attempts to construct an analysis of these meanings by analysing participants' words and actions (Schwandt, 1994). Thus individuals actively create their own understanding of the world and develop their own personal knowledge (Lauder, 1996). Guba and Lincoln (1994:113) state that knowledge "*consists of those constructions about which there is relative consensus (or at least some movement toward consensus)...*" These authors also recognise that "*multiple knowledges*" (Guba and Lincoln, 1994:113) can exist together and that a range of views can emerge during a naturalistic inquiry. The aim of constructivist inquiry is thus to develop a body of knowledge in the form of shared constructions that illuminate a particular context.

The constructivist paradigm has been developed from five principles. These are:

- reality and its elements
- causality
- unique contexts resulting in absence of generalisation,
- the relationship between the researcher and the phenomena under study
- the impact of values on the inquiry process

(Guba and Lincoln, 1982; Lincoln and Guba, 1985).

The following discussion will examine the five principles of constructivism in contrast with the traditional scientific perspective, through an exploration of ontology, epistemology and methodology.

4.5.1 Reality and its elements

Ontologically the conventional paradigm assumes that there is a single, tangible, objective reality "*ascertainable through the five senses, subject to universal laws of science, and manipulable through the logical processes of the mind*" (Erlandson et al, 1993:14). Positivism "*is rooted in a realist ontology, that is, the belief that there exists a reality out there, driven by immutable natural laws*" (Guba, 1990:19). These natural laws are regarded as being time and context free. Thus positivism asserts that reality exists independently of any interest the researcher might have in it (Guba and Lincoln, 1989). Guba and Lincoln (1989) state that within the conventional paradigm 'truth' is the set of statements exactly corresponding to reality. Science is concerned with trying to discover the 'true' nature of reality and how it works.

In contrast to positivism the constructivist paradigm holds the view that multiple and intangible realities exist which are not governed by natural laws. Reality is not viewed as something "*out there, independent of human consciousness*" (Neuman, 1994:62). Reality is viewed as pluralistic. This means that within any research study there will always be many different interpretations that can be made. Constructivism thus supports a relativist ontology because it is impossible to determine the ultimate truth or falsity of these various constructions (Guba and Lincoln, 1982, 1989; Guba, 1990). Bullock et al. (1988:736) define relativism as:

> *the view that beliefs and principles particularly evaluative ones, have no universal or timeless validity but are valid only for the age in which, or the social group or individual person, by which they are held.*

Constructivists believe that social reality exists as individuals experience it and assign meaning to it. It "*is a constructed set of meanings*" which reflects the beliefs which people hold (Lincoln and Guba, 1985:78). Such understanding is created through people's actions and social interactions with others via a continual process of interpersonal communication and negotiation. Lincoln and Guba (1985:73) state:

> *personal reality* [is] *self-created. We put together our own personal reality. It is made up of our interpretation of our perceptions of the way things are and what has happened to us.*

This recognition of an individual's ability to perceive in a unique manner differs from the positivist viewpoint which assumes that every person experiences reality in the same way (Neuman, 1994).

There are clearly many different perceptions of reality. Stake (1977) has suggested that researchers will find "*multiple truths*" and sometimes contradictory understandings during the course of their research studies. Lincoln and Guba (1985:77) refer to Bogdan and Taylor's (1975:11) view that "*truth then emerges not as one objective view but rather as the composite picture of how people think.*" 'Truth' is defined in the constructivist paradigm as "*the best informed and most sophisticated construction on which there is consensus at a given time*" (Schwandt, 1994:127). In this type of research each individual's experiences and the contexts in which they occur are considered valid and integrated into the emerging construction(s). This differs markedly from traditional inquiry, which seeks a single or a minimum number of correct viewpoints.

In constructivism all interpretations are deemed to be equally valid and important, the researcher does not disregard divergent or conflicting constructions of reality. In order to maintain trustworthiness researchers must detail the multiple realities they unearth. It is therefore crucial that contextual factors are taken into account to reach a holistic understanding.

4.5.2 The possibility of causal linkages

Searching for causality appears fundamental to the positivist paradigm. Ontologically positivism seeks to discover natural laws in order that people can manipulate, predict and control events and phenomena (Neuman, 1994). This viewpoint arises from the philosophical stance that reality is governed by "*immutable natural laws*" (Guba, 1990:20). Positivists believe that every action can be interpreted as the consequence of some causal event (Guba and Lincoln, 1982) and that at the very least these causal relationships can be established probabilistically. Ultimately they believe that causal laws can explain people's actions and behaviours and that the most appropriate method for demonstrating these cause and effect relationships is the experiment (Guba and Lincoln, 1982).

However, constructivists believe that the concept of causality is misleading, too simplistic and that the process of assembling meanings does not simply happen in a linear fashion. Causality has been heavily criticised with many researchers stating that it cannot explain what is happening in complex social situations (Lincoln and Guba, 1985; Heron, 1981) and that it is impossible to remove the influences of "*human experience, judgement and insight*" (Guba and Lincoln, 1989:97).

Guba and Lincoln (1985:37) reject the concept arguing that because "*all entities are in a state of mutual simultaneous shaping, ... it is impossible to distinguish causes from effects.*" 'Mutual simultaneous shaping' means that all things influence each other and that "*causes and effects are inextricably intertwined*" (Guba and Lincoln, 1982:242). Indeed many different effects could be produced by the same cause. Rowan and Reason (1981:129) cite Palazzoli et al. (1978) who state:

> *it is epistemologically incorrect to consider the behaviour of one individual the cause of the behaviour of others. This is because every member influences the others, but it is in turn influenced by them. The individual acts upon the system, but is at the same time influenced by the communication he receives from it ....*"

Constructivists believe that people should be studied in their natural environments and as such it is impossible to isolate the particular "*cause effect connections*" (Guba and Lincoln, 1982:242) because people's behaviour is so closely linked to time and settings. Any observed event or action is influenced by multiple factors and is shaped through a dynamic and interactive process. Instead researchers can only make "*plausible inferences about the patterns*" (Guba and Lincoln, 1982:238) and relationships observed in each context or within each case. "*Explanations are at best 'here-and-now' accounts that represent a 'photographic slice of life'*" (Guba and Lincoln, 1989:98). The nature of constructions depends on the meanings which people attribute to them. This means that any construction which results from a constructivist inquiry may be regarded as unique, for a particular set of circumstances may never occur again in exactly the same way.

4.5.3 Unique contexts results in absence of generalisation

The aim of positivism is to develop a nomothetic body of knowledge, which can be generalised from one case to another. Generalisations are defined as "*truth statements of enduring value that are context-free*" (Guba and Lincoln, 1982:238) and timeless. This contrasts with the constructivist viewpoint where 'truth' is regarded as relative. Lincoln and Guba (1985) and Erlandson et al, (1993) argue that seeking generalisations is not meaningful when studying human behaviour as it is impossible "*to imagine that all human activity is completely determined by one universal set of relationships*" (Guba and Lincoln, 1989:94). Generalisations cannot be separated from time and context, they "*inevitably decay over time, and they inevitably have contextual dependencies*" (Guba and Lincoln, 1989:96). Constructivists argue that "*no two social settings are sufficiently similar to allow simplistic, sweeping generalisations*" between the two (Erlandson et al, 1993:13). Instead the uniqueness of the study settings is valued. It is the context specific actions and interrelationships that influence people's interpretations and which give the data meaning (Erlandson et al, 1993; Neuman, 1994).

Constructivist inquirers attempt to give the reader a feel for other people's social reality by reporting a detailed description of the cases under study. It is these interpretations which "*depend so heavily for their validity on local particulars*" (Lincoln and Guba, 1985:42). As an implicit part of constructivist inquiry the researcher reports and make sense of the uniqueness discovered in each study setting (Lincoln and Guba, 1985). Constructivists recognise that generalisability is unachievable as no two settings are ever identical and contexts change over time. However, through 'thick description' readers may find clear similarities between settings which gives them confidence to apply the results of a study to their own practice (Sandelowski, 1986, 1993; Lincoln and Guba, 1989).

4.5.4 The relationship between the researcher and the phenomena under study

Objectivity continues to be the aim of the positivist paradigm and therefore the positivist adopts a distant and non-interactive stance with the object of inquiry. However, as Guba and Lincoln (1989) note objectivity is not applicable in

constructivism where the belief is that reality consists of multiple mental constructions. People construct meanings about the world through interactive experiences with others (Guba, 1990). The interaction which takes place between the researcher and respondent "*renders the distinction between ontology and epistemology obsolete; what can be known and the individual who comes to know it are fused into a coherent whole*" (Guba, 1990:26). It is simply not feasible to detach the researcher and the phenomena under study. In the constructivist paradigm, findings are "*the creation of the process of interaction*" (Guba, 1990:27) between the inquirer and study participants. Guba and Lincoln (1989:88) note that "*it is precisely their interaction that creates the data which will emerge from the inquiry.*"

Throughout the whole inquiry process, researcher and respondents are constantly influencing each other. For example, in the initial stages of a constructivist study the researcher is more likely to gain access to the study sites and achieve a purposive sample by engaging in discussion with potential participants. When collecting data, an interviewer will have expectations about respondents and may adapt questions and personal approach accordingly. Furthermore participants "*are constantly being shaped by their perceptions and expectations about the researcher and his or her use of the data*" (Lincoln and Guba, 1985:99). A "*mutual shaping*" (Lincoln and Guba, 1985:100) takes place which is influenced by both researcher and respondent value systems.

Lincoln and Guba (1985:99) recommend that constructivist researchers "*capitalise*" on this interactive process which is fundamental to the researcher discovering the multiple views of reality that may exist. Human researchers are recognised as being extremely adaptable and flexible. Researchers can respond to situations by the effective use of interpersonal skills and by applying creativity and intuition to adapt data collection procedures. Interaction continues throughout data analysis through the hermeneutic/dialectic process when the investigator seeks convergent and divergent viewpoints. As Erlandson et al. (1993:114) state "*this interactive refining process never really ceases until the final report has been written.*"

4.5.5 Values

Positivists believe that researchers must take an objective, distant and non-interactive stance to study aspects of the social world. "*Values and other biasing and confounding factors are thereby automatically excluded from influencing outcomes*" (Guba, 1990:20). In contrast, constructivists argue that the values and preconceived ideas of the researcher and others, such as grant funding agencies always influence the inquiry design and processes (Guba and Lincoln, 1989). Guba (1990) states that no inquiry can be value free, constructivist researchers see values everywhere, therefore values must be acknowledged and their potential difficulties addressed.

Constructivist inquiry seeks to develop consensus constructions "*in which 'facts' and 'values' are inextricably linked*" (Guba and Lincoln, 1989:109). Two people experiencing the same "*facts*" (Guba, 1990:25) can interpret this information differently depending on their own value systems and experiences. Constructivists argue that facts are both "*value-laden*" (Guba and Lincoln, 1989:105) and "*theory laden*" (Guba and Lincoln, 1989:105). Lincoln and Guba (1985:162) state that "*if theories are value-determined and facts are theory laden, then facts must also be value-determined.*" Values are seen as essential in knowledge creation within the constructivist paradigm.

Guba and Lincoln (1982) have suggested that values influence constructivist inquiry in four different ways. Initially the beliefs and values of the researcher will influence the problem or area of investigation. Secondly, the particular theoretical paradigm and methodology selected to guide the inquiry process will have roots in both "*assumptions and value position*[s]" (Guba and Lincoln 1982:243). Thirdly, the study will be influenced by the presence of values ingrained in study contexts. Finally, the beliefs of all groups represented in a study are recognised as influential and "*deserve equal consideration in shaping constructions*" (Guba and Lincoln, 1994:114).

4.6 Why undertake a constructivist inquiry ?

A constructivist methodology has been adopted in the main study as the researcher was attempting to achieve some understanding about the complex nature of health visitors' professional judgements. The focus of interest in this study was to try and

understand the factors that may influence a health visitor in making a judgement to offer a family extra support and to find out what the essence of that support might be. The researcher was attracted by constructivism's ready acknowledgement that inquirer values and personal interests influence the nature of research inquiry. As described in Chapter 3, the researcher's preliminary work in this area had been instrumental in developing her thinking on the subject. Currently limited empirical evidence exists about the nature of health visitors' professional judgements in determining to increase support to certain families. Achieving some understanding of professional judgement and the influence of formal guidelines is a complex and evolving issue, yet such clarification is urgently needed. In today's economic climate where the value of preventative services is increasingly being questioned, there is a real need for health visitors to articulate and account for their practice effectively.

To develop knowledge about this important but neglected area of practice, it was deemed crucial to study health visitors at work with clients in their own social contexts, which is a central feature of this philosophical approach. A constructivist inquiry seeks understanding by examining phenomena in their natural environment. Ontologically constructivists believe that "*realities are wholes which cannot be understood in isolation from their contexts, nor can they be fragmented for separate study of the parts*" (Lincoln and Guba 1985:39). Indeed Chapter 2 signified the potential influence of the practice context in the elucidation of judgement, reasoning and decision making. Furthermore in the preliminary study (Chapter 3), the existence of differing guidelines across Community Trusts implies a need to incorporate a focus on context when studying health visitor professional judgement. This mode of inquiry affords the researcher the opportunity to consider individual's actions and perceptions in seeking to understand the variety of constructions which people hold. It readily acknowledges the existence of competing views and therefore seems highly suitable for the study of health visiting practice, where multiple approaches to judgement formation are likely to exist.

This type of inquiry is needed in health visiting to consider individual motives and meanings and to seek to find out the reasons people give for their actions. Constructivists believe that a person's actions and behaviour can only be explained in

terms of multiple interacting factors. Its rejection of the ability to determine causal relationships appears appropriate for the study of professional judgement, which as the literature has alluded to, is likely to be influenced by a range of factors including contextual elements. Guba and Lincoln (1982:238) have suggested that the most appropriate method for interpreting patterns and relationships is to study them "*holistically and in their natural contexts*." Therefore the adoption of an interactive epistemology can help to facilitate close interaction between researcher and participants and was deemed highly appropriate for the study of health visitors' working practices with clients.

By undertaking a constructivist inquiry the researcher determined to unpack the processes involved in health visitor professional judgement. It was intended that some consensus of opinion would be reached and important insights gained about health visitor professional judgement in identifying health needs and prioritising families requiring extra support. It was hoped that the detailed constructions resulting from the inquiry would facilitate health visitors to demonstrate and articulate their practice more clearly to managers, other professionals and commissioners of community health services.

4.7 Chapter summary

This chapter has outlined the aims and objectives of the main study. It has provided a detailed exposition of the philosophical underpinnings of the constructivist research paradigm, by critically examining its five philosophical principles in comparison with positivism. Finally it has sought to explore why this is an appropriate approach to utilise in the detailed examination of 'real life' health visiting practice. Chapter 5 will move on to describe the study design. It will explore how a case study strategy guided by a constructivist methodology has been used to examine health visitors' professional judgements and use of formal guidelines in identifying families requiring extra health visiting support.

Chapter 5

Study Design

5.1 Introduction

This chapter will build on the philosophical underpinnings outlined in the previous chapter. It will demonstrate how a case study strategy guided by a constructivist methodology was used to facilitate the integration of multiple sources of data. The chapter will outline a framework for constructivist investigation developed specifically for nursing research from the original work of Lincoln and Guba (1985). This framework is used to detail the steps of the research methodology and explicate the researcher's decision making in examining the concept of professional judgement.

5.2 Research Strategy – An outline of the case method

The strategy of inquiry used in the main research study was the case study, which facilitated the integration of multiple sources of data and was guided by a constructivist methodology. Yet, there is much confusion about the case study. The literature indicates that there is a lack of clarity about what determines 'a case' and this situation is exacerbated by the fact that 'case studies' have been used in several different ways (Lincoln and Guba, 1985; Mariano, 1993; Ragin, 1992). For example, Meier and Pugh (1986), Yin (1993;1994), Stake (1994;1995) and Sharp (1998) all regard case study as a research strategy, yet Lincoln and Guba (1985) view it as a technique for reporting naturalistic inquiry findings, while others describe case studies as evaluation tools (Patton, 1990; Yin, 1993; Marshall and Rossman, 1995).

Further complications emerge from the fact that many different definitions of the term 'case study' exist in the literature. One of the most popular is proffered by Yin (1994:13) who regards case study as "*an empirical inquiry that investigates a*

contemporary phenomena within its real life context, especially when the boundaries between phenomena and context are not clearly evident" and *"in which multiple sources of evidence are used"* (Yin, 1984:13). Robson (1993:5) defines case study similarly to Yin (1994), while Stake (1994:237) provides a less specific definition, stating that it *"is both the process of learning about the case and the product of our learning."* The *"intensive"* and *"in-depth"* nature of this type of investigation is further highlighted by Powers and Knapp (1990:17) and Woods and Catanzaro (1988:553).

From these definitions it can be determined that case study is an intensive analysis in which the inquirer attempts to examine and understand key variables which are important in determining the dynamics of a situation, in order to provide detailed insight into the phenomenon of interest. In an attempt to clarify confusion, Sandelowski (1996:526) has suggested that case study:

> *refers to both a process of inquiry (studying a case, or designing and executing a case study) and its end product (the case study or case report).*

Many researchers have documented the fact that case study research can be either quantitative or qualitative, or a synthesis of both approaches (Runyan, 1982; Yin, 1994; Stake, 1994; Sandelowski, 1996). Furthermore, a variety of methods can be used in the collection of multiple sources of data to gather a more complete picture about the topic of interest.

5.3 Selecting an approach to case study

The major proponents of case study research are Robert Yin (1993; 1994) and Robert Stake (1995) who in their respective texts offer two quite different approaches to case study research. Yin (1993; 1994) favours both qualitative and quantitative approaches to case study, whereas Stake (1995) offers an approach which is essentially rather philosophical and focuses purely on qualitative aspects. Embarking on a constructivist inquiry of health visitor professional judgement the researcher needed to adopt an approach to case study that was commensurate with the philosophical underpinnings of constructivism, yet the research literature provided little help. This dearth of relevant material was surprising, and may indicate the fact that researchers

undertake case study with an apparent neglect of, or a limited understanding of the underlying philosophy of the method. This section will attempt to explicate the decision making processes used to assess the relevance and appropriateness of these two approaches for the current constructivist study. The following discussion will present a comparison of the perspectives of Yin (1994) and Stake (1995) using the following parameters:definition of a case, type of case study, rationale for method, paradigmatic orientation, sampling strategy, use/location of theory and time. These comparative elements are summarised in Table 5.1.

Table 5.1: Case study – A comparison of the perspectives of Robert Yin and Robert Stake[1]

Comparative elements of case study	*Yin*	*Stake*
Definition of a case	A case is a contemporary single unit, phenomena or issue of study, in context.	"The case is a specific, a complex, functioning thing" ... each case "is an integrated system" and "has a boundary and working parts" (Stake, 1995:2).
Types of case study design	The case study design can be single (either holistic or embedded) or multiple, as well as descriptive, exploratory or explanatory	Three types of case study design:- intrinsic, instrumental or collective case study
Rationale for method	Suitable for the study of:- - 'how' and 'why' questions - focus is contemporary issue(s) or unit(s) in real life settings - where no researcher control - using multiple sources of data - for qualitative and quantitative approaches.	Suitable for the study of:- - contemporary issue(s) or unit(s) - in real life settings - where no researcher control - using multiple sources of data - focusing on qualitative inquiry - to construct an in-depth understanding of a single case/issue or multiple cases.
Paradigmatic orientation	Positivism and post-positivism.	Interpretivism - constructivism.
Sampling approach	Replication logic. Potential for . literal replication or theoretical replication	Purposive sampling.
Use location of theory	1. Case study should ideally be guided by theoretical propositions 2. Through the use of 'analytic generalisation' case study results may be generalised to an existing theory.	Theory may emerge through the case study, but there is no insistence on theory development.
Time	Considerable time needed for the intensive and detailed study of the case.	Considerable time needed for the intensive and detailed study of the case.

(Summarised from: - Yin, 1993, 1994; Stake, 1994, 1995).

5.3.1 Definition of a case

A number of researchers (Ragin, 1992; Yin, 1994; Stake, 1995; Woods, 1997) have noted that the key difficulty when utilising the case study strategy is the problem of clearly articulating what is 'the case'. There is a general lack of clarity in the literature about what can actually constitute a case and this does present difficulties. Sandelowski (1996:526) has explained that the purpose of examining a case is "*to optimise understanding of the One.*" A case or "*one*" can be either an individual, a group, an activity, an incident, an organisation/structure or several organisations (Stake, 1995; Woods, 1997; Creswell, 1998; Cowling, 1998). However, both Bromley (1986:25) and Mariano (1993) go further stressing the study of the unit "*in a situation*". Indeed, Yin (1994:13) describes a case as a contemporary single unit or phenomenon of study examined in context, where the boundaries between the two are not clearly distinct.

Bromley (1986) and Ragin (1992) also suggest that a case can be a process. However, Stake (1995:2) describes the case as "*a bounded system*", an "*object*" of study which provides opportunities for learning. He (1995:2) states "*the case is a specific, a complex, functioning thing*" and suggests that each case has "*a boundary and working parts*". Furthermore, Stake (1978:7) emphasises that it is important to identify "*what is and what is not "the case"*" and like Ragin (1992) and Mariano (1993) highlights the importance of clearly depicting the boundaries of the case study investigation.

Ragin (1992:6) also suggests that many "*researchers will not know what their cases are until the research, including the task of writing up the results, is virtually completed.*" This adds a further dimension and seems to indicate that researchers cannot possibly be aware of all facets of the case at the beginning of an inquiry and that the make-up of a case is likely to unfold only as the study progresses. Faced with these miscellaneous viewpoints it seems important to consider what is the purpose of defining the case. From the researcher's own perspective, what seems to be important is not purely describing its substance, but clarifying how the case will inform data collection and lead to an understanding of the phenomenon of interest.

5.3.2 Type of case study

The researcher found it useful to examine the different types of case study associated with the perspectives of Yin (1993; 1994) and Stake (1994;1995). Yin (1993) states that case study research can focus on either a single or on multiple cases and can be further defined as descriptive, exploratory or explanatory. A descriptive case study design documents a full account of the phenomenon of interest within its context (Yin, 1993). An exploratory case study "*... is aimed at defining the questions and hypotheses of a subsequent ... study or determining the feasibility*" of a research project (Yin, 1993:5), while the explanatory case study attempts to demonstrate causal relationships.

Stake (1994;1995) however, suggests that it may not always be possible to place case studies into particular categories, but does describe three different types of design. Firstly, 'intrinsic case study' which is undertaken when a researcher wishes to seek clarity and understanding about an individual case (Stake, 1994; 1995). In this type of design, the unique case is of interest (Stake, 1994). Secondly, he describes 'instrumental case study' in which "*a particular case is examined to provide insight into an issue or refinement of theory*" (Stake, 1994:237). In this design the case is not the primary focus instead the case is used to explore and comprehend another issue. The third type, 'collective case study' is essentially an instrumental case study expanded to incorporate a larger number of cases. It occurs when a researcher studies a number of cases together to explore an event, population or phenomenon.

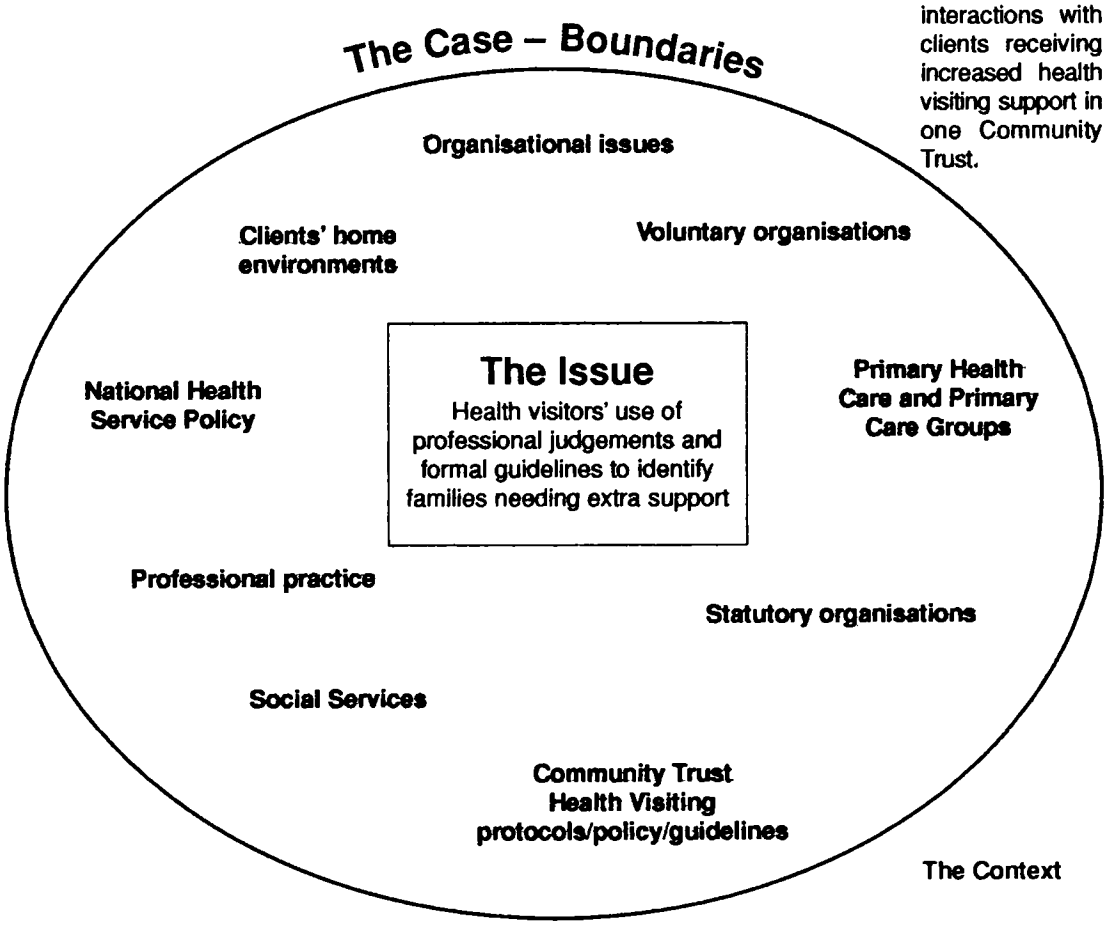
For the purposes of this investigation in which the researcher was attempting to capture some of the issues and complexities surrounding health visitors' professional judgements in 'real life' contexts, the case study was regarded as instrumental in design. This was because the researcher was attempting to further her knowledge and understanding of professional judgement, rather than focusing on the particular health visitors, clients or the Community Trusts. Where an instrumental study is broadened to include more than one case, it is termed a collective case study. In this study, the researcher was intending to examine health visitors' use of professional judgements and formal guidelines in identifying vulnerable families in three separate Community Trust sites, where different formal guidelines existed. By selecting three slightly different

cases the intention was to try and increase understanding about the phenomenon of interest, professional judgement; thus a collective case study was undertaken.

Defining the case in this study

Findings from preliminary research work and the literature on health visitor assessment practices indicated that health visitors' judgements to increase support levels to families might be influenced by multiple interacting contextual factors. These could include:-Community Trust policy, protocols and guidelines, clients' home environments, government health policy, social services, voluntary and statutory organisations and professional practice issues. Thus the three cases selected for this study needed to include all these factors and possibly other significant elements which may emerge during the study's progress (Ragin, 1992). Each case has therefore been defined as 'health visitor interactions with clients receiving increased health visiting support in one Community Trust' in the context of the above interacting factors (See Figure 5.1: Case context and issue).

Figure 5.1: Case, context and issue



5.3.3 Rationale for method

Case study is a particularly useful strategy when little is known about an issue. It seemed an ideal approach for exploring professional judgement in health visiting. Case study was selected as the researcher intended to undertake a detailed examination of a contemporary issue (health visitor professional judgement in determining families requiring extra support), within a real life context (the health visiting service) using multiple sources of data to elicit greater understanding about the case. In choosing case study for this exploratory qualitative inquiry, the researcher could have adopted either Yin (1993, 1994) or Stake's (1995) method as the preferred strategy. For both approaches emphasise the importance of studying phenomena in their natural and uncontrolled environments, where multiple sources of data are used, the focus is in-depth understanding and the inquirer "*attends to cases as wholes and strives to comprehend their essence*" (Sandelowski, 1996:526). Stake (1994) however does emphasise that his approach to case study is qualitative in nature.

Yin (1994:1) has outlined a number of factors which need to be considered when determining whether case study is an appropriate research strategy to utilise in a study:

- *the type of research question*
- *the control an investigator has over actual behavioural events*
- *the focus on a contemporary phenomenon within some real-life context.*

He also stresses that case study is the preferred approach when "*how*" and "*why*" questions are being asked (Yin, 1994:1). However, it also seems important to consider the researcher's preferred epistemological and philosophical viewpoint (Woods, 1997). In this study, the researcher needed to adopt an approach to case study that was consistent with constructivist assumptions (See 4.6.).

5.3.4 Paradigmatic orientation

Although Yin (1984; 1993; 1994) advocates both qualitative and quantitative approaches to case study, Stake (1995) regards Yin's (1994) text as essentially quantitative in focus. Yin's (1984) distinctive case study design certainly appears to have developed from a positivist viewpoint although in his first book on 'Case Study

Research Design' he does not explicitly state this. Interestingly in a later applied work Yin (1993:47) is clearer about the philosophical roots of his work, saying:

> *... the approach here has been to base case study research within the framework of the scientific method – to develop hypotheses, collect empirical data, and develop conclusions based on the analysis of such data.*

Furthermore and to his credit Yin (1994) provides clear and fairly prescriptive guidance for those embarking on a case study investigation.

Stake (1995) on the other hand offers an approach to case study research that is rather philosophical and focuses purely on qualitative aspects. The terminology which Stake (1995) uses in his text 'The Art of Case Study Research' is certainly more in keeping with a constructivist viewpoint than the language used by Yin (1993; 1994). He is also less prescriptive than Yin (1993; 1994) though at a cost. Whilst Stake's (1995) text does provide examples from case study research, it is somewhat vague in its overall approach and offers limited clear guidance about undertaking a qualitative case study.

It would appear that Stake's (1995:99) approach to case study is closely influenced by a constructivist epistemology "*the belief that knowledge is constructed rather than discovered*" and the belief that inquiry can never be value free. He states that "*no aspects of knowledge are purely of the external world, devoid of human construction*" (Stake, 1995:100) and that multiple views about the case should be described. Indeed Stake's (1978; 1994; 1995) approach to case study appears to be consistent with some of the key principles of constructivist inquiry. For example, Stake (1994) recognises the impact of unique contexts and their influence in shaping each individual case.

The case study strategy also fits well with the requirements of a constructivist ontology that emphasises the holistic nature of realities and the importance of studying phenomena in natural uncontrolled contexts. It is also useful for studying multiple realities, because many issues can be examined in-depth within a particular context. As Stake (1995:8) notes "*the real business of case study is particularisation, not generalisation*" and its focus on the emic perspective. This approach emphasises the uniqueness of situations, which reflects Lincoln and Guba's (1989:22) emphasis

on "*idiographic interpretation*" and relevance of local particulars. The final case study report often provides rich, complex and holistic descriptions about the phenomena under study. Such reports can help readers in their own construction of knowledge through vicarious experiences (Guba and Lincoln, 1994; Stake and Trumbell, 1982; Stake, 1994).

The researcher using a constructivist framework may feel uncomfortable with Yin's (1993; 1994) approach for a number of reasons. Firstly, there does not appear to be any recognition in Yin's (1993; 1994) work of the importance of intuitive processes in the research process. A further feature of Yin's (1993; 1994) approach, which stems from its positivist roots, is the fact that he recommends researchers use traditional quantitative criteria to evaluate the quality of a case study. These criteria do not fit well with the constructivist paradigm, where researchers address issues of trustworthiness and rigour through the use of 'truth value', 'applicability', 'consistency' and 'neutrality' (See 5.11).

Another area of conflict for constructivist inquirers surrounds the issue of explanatory case studies where Yin (1993; 1994) explains the researcher is concerned with presenting data to explain causal relationships. Certainly constructivists would argue that it is impossible to explicate causes from effects, as discussed in Chapter 4. The quality criteria of internal validity is therefore not regarded as a suitable measure in a constructivist inquiry.

On closer examination other features of Yin's (1993; 1994) case study strategy are inherently not in harmony with a constructivist methodology. For example, Yin's (1994:54) recommendation that each case study should be preceded by a planned "*protocol*" to guide the investigation. Such formal statements of intent provide direction for researchers undertaking a case study and are important in increasing the reliability of the research (Yin, 1994). However, the protocol features are quite alien to the constructivist paradigm where detailed design issues "*cannot be given in advance*" (Lincoln and Guba, 1985:225), but instead emerge as the researcher interacts with study participants and begins to get a sense of important issues. This was certainly important

in the current study, where the researcher had few preconceived ideas about the concept of professional judgement and needed to refine her thinking as the study progressed.

Lincoln and Guba (1985:226) state that:

> *design in the naturalistic sense ... means planning for certain broad contingencies without, however, indicating exactly what will be done in relation to each.*

Therefore while it is appropriate for a constructivist study to have clearly defined objectives and initial plans for preliminary data collection, these plans are not set in tablets of stone and are often tentative (Appleton and King, 1997). This viewpoint contrasts markedly with Yin's (1994:24) positivistic approach, which recommends case study researchers formulate propositions, time boundaries "*to define the beginning and end of the case*" and establish the boundaries of data collection and analysis processes.

5.3.5 Sampling approach

Whether Yin (1993, 1994) or Stake's (1995) approach to case study is adopted both aim to fully explore and understand the particular case or cases selected. Yin (1994:32) suggests that the selection of a case will emerge by clearly specifying the study's research question with a potential "*aim toward analytic generalisation*". He compares the selection of individual cases (through replication logic) to a laboratory researcher choosing topics for experimentation (Yin, 1994). He states that multiple cases should be selected at the beginning of a study to either:

> *(a) predict similar results (a literal replication) or (b) produce contrasting results but for predictable reasons (a theoretical replication).*
> (Yin, 1994:46)

A constructivist inquiry would contain no such explicit assumptions at the outset, but should be influenced by the multiple realities that are encountered as the study unfolds.

Stake (1994:236) argues that the purpose of case study research is to "*optimise understanding of the case*". A case is initially selected because of the opportunities it

offers for learning (Stake, 1994). The inquirer then attempts to seek out the complexities of the case to provide greater insight into the issue of interest. This reflects an adoption of purposive sampling techniques to gather "*information rich cases*" (Patton, 1990:169), with the intention of building up a range of information and constructions about the case(s).

In the current study the researcher had no preconceived a priori theory or specification about sample selection for the main study. Instead insights were to emerge following preliminary work and the analysis of documentary evidence (Chapter 3) which influenced main study sampling.

5.3.6 Use/location of theory

Yin (1994:28) argues that a fundamental stage in case study research is that prior to data collection "*theory development*" should take place which can direct subsequent data collection and analysis processes. Yin (1993:xiii) states that the function of theory is two-fold: "*not only is* [it] *helpful in designing a case study but it also later becomes the vehicle for generalising a case study's results.*" He points out those naturalists such as Lincoln and Guba (1985) and Stake (1983) "*attempt to avoid prior commitment to any theoretical model*" (Yin, 1994:14) and he clearly regards this stance as a weakness. However, constructivists would argue vehemently that it is impossible to adopt a theoretical framework at the beginning of the study as not enough can be known about the constructed realities which may exist in the context under investigation. The constructivist researcher prefers to regard theory as "*emergent*" (Erlandson et al, 1993:16).

Case study research has been traditionally criticised for the inability to generalise findings from one or a limited number of cases (Mitchell, 1983; Mariano, 1993; Dale, 1995). Yin (1994) acknowledges that formal or statistical generalisation (gained by generalising from the study sample to the wider population) is not appropriate in case study research. Instead Yin (1994:36) supports "*analytic generalisation*" in which the researcher strives "*to generalise a particular set of results to some broader theory*" and to use this "*as a template against which to compare the empirical results of the*

case study" (Yin, 1993:50; Firestone, 1993). This raises two problems for the constructivist inquirer, firstly in the fact that the constructivist is attempting to construct knowledge and theory that is exclusive to the particular context under study. Preferring to view constructions as unique contextual entities, he/she is certainly not attempting to generalise findings to some existing theory.

Secondly, in constructivism the concept of generalisability is modified to that of transferability, with the responsibility lying with those who seek to apply the study findings to other settings (Lincoln and Guba, 1995). This latter view is supported by Stake (1994) who disapproves of researchers focusing on the potential generalisability of cases which he terms the "*typification of other cases*" (Stake, 1994:238) rather than their intrinsic and uniquely individual worth.

In contrast to the positivist view of generalisation, Stake (1995:85) states that "*case studies are undertaken to make the case understandable*". He appears to adopt the view of fittingness as outlined by Lincoln and Guba (1985) and suggests that 'naturalistic generalisations' may be achieved when others read the final case study report and view the findings as meaningful in terms of their own experiences. This highlights the need for researchers to describe case study contexts in detail "*to develop vicarious experiences for the reader, to give them a sense of 'being there'*" (Stake, 1995:63).

5.3.7 Time

Both approaches to case study acknowledge that intensive and detailed study of the case takes time (Yin, 1994; Stake, 1995). This intensive period of investigation can last a relatively short time (e.g. a few days) or can continue for many years, as is often the case in social anthropology (Mitchell, 1983; Sharp, 1998). The researcher scrutinises the phenomenon of interest in an exhaustive fashion and having sufficient time can facilitate the collection of multiple sources of data to inform understanding about the case. It is only through thorough immersion in the study context, that a researcher is able to unearth the intricacies and subtleties of the case.

This recognition of the importance of the time element of a case study inquiry fits particularly well with constructivism. Constructivists highlight the time needed for researchers to build up contacts and relationships with potential respondents before beginning to understand their constructions of reality (Erlandson et al, 1993). This has been a crucially important factor in the current study where the researcher has spent considerable periods of time gaining access to study sites, using skills of diplomacy and sensitivity. A researcher using this methodology has to recognise the importance of effective communication at many levels (Appleton and King, 1997). At the end the day, the process of gaining access and the progress of the case study will rely on participants' good will.

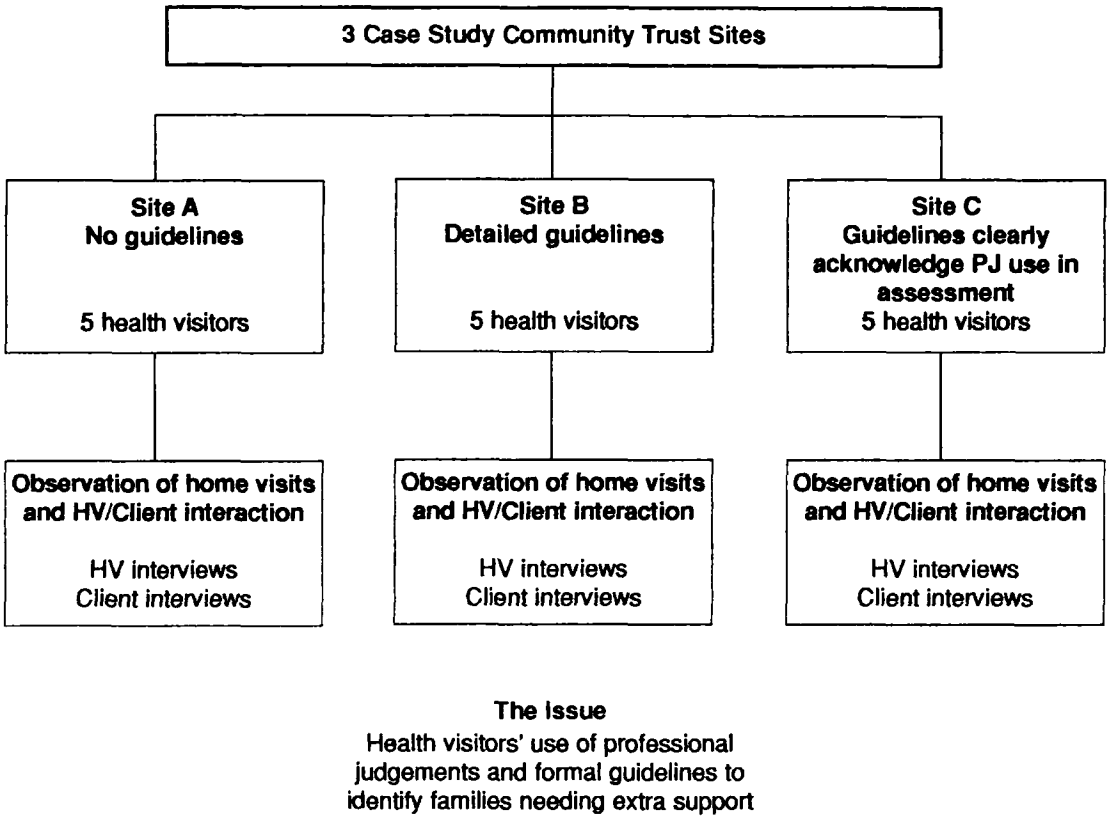
5.3.8 Case study – Summary

Case study has much to offer the intrepid researcher intending to study a current practice issue within its real-life context. This section has attempted to critique the two quite different approaches to case study research offered by Yin (1994) and Stake (1995), and to assess their potential relevance for use within a constructivist inquiry of health visitor professional judgement. While both approaches clearly have strengths and weaknesses, this section has offered an explanation as to why Stake's (1995) approach to case study research fits most appropriately with constructivism's philosophical roots. Fundamentally in adopting a particular author's approach to case study, a researcher should carefully consider his/her own philosophical standpoint and be clear that they can justify methodologically the particular approach adopted. It no longer seems acceptable to state that one is undertaking a 'case study' without being clear and consistent about the particular approach adopted.

Certainly in the current study, Stake's (1994; 1995) description of instrumental case study research has been helpful in determining the nature and boundaries of each case. However, the key reason for adopting a case study strategy in this study is that it offers the constructivist a framework for sampling cases which can then be helpful in structuring the organisation and analysis of the triangulated case study data (Figure 5.2). Case study is a particularly useful approach for examining a phenomenon in its natural context, recognising the complexities of 'real life' settings and integrating

multiple sources of evidence. It seemed an appropriate strategy for examining in more depth the issue of health visitor professional judgements in determining families needing extra support.

Figure 5.2: The Case Study Investigation – A Constructivist Approach



5.4 A Framework for Constructivist Investigation

The remainder of this chapter will outline the use of the constructivist methodology using a framework developed specifically for nursing research from the original work of Lincoln and Guba (1985). The key components of Appleton and King's (1997) framework are illustrated in Figure 5.3, although it must be noted that the stages of presentation have been slightly modified to fit the particular idiosyncrasies of this study and to reflect the interwoven nature of many stages.

5.5 Tentative research design – Selecting case study sites

The emergent nature of a constructivist inquiry means that initial research plans can only be tentative. Nothing is certain, as the researcher grapples with the complexity of context and its impact on the evolving study. This chapter began by describing the decision making processes used to structure the study and the thinking behind the

Figure 5.3: Framework for constructivist investigation in nursing research.

Adapted from: Lincoln and Guba, 1985 and Appleton and King, 1997

adoption of Stake's (1995) approach to case study design. It outlined how, even at this early stage, that the initial design was beginning to unfold within a constructivist framework. This section will describe how the search for the case study sites progressed.

In constructivist inquiry, selecting suitable site(s) to study the phenomena in context is a crucially important aspect of the research process and ultimately influences the quality and *"viability of the whole study"* (Erlandson et al, 1993:53). Site selection should closely follow the determination of the research question or aim. Erlandson et al. (1993:53) stress the importance of identifying *"a site that maximises*

the opportunity to engage the problem." The aim is to build up a range of information and constructions about the phenomenon and context.

Marshall and Rossman (1995:51) outline four features of the ideal study site, that:

- *entry is possible*
- *there is a high probability that a rich mix of the processes, people, programs, interactions, and structures of interest are present*
- *the researcher is likely to be able to build trusting relations with the participants in the study*
- *data quality and credibility of the study are reasonably assured.*

It is also important that the researcher feels comfortable in the selected site(s) and feels able to blend in to the research situation.

Pilot and main study sites were initially identified using information gained from the postal survey undertaken during preliminary research work (See Chapter 3). Respondents were asked to indicate if they were interested in allowing their health visiting workforce to be approached to participate in the main study. Of the 149 Senior Nurses responding to this offer, 89 (59.73%) stated that they were willing to allow their health visitors to take part.

At this stage, the researcher had no preconceived specification about sample selection for the main study. Instead insights emerged following analysis of the questionnaire data and documentary evidence (Chapter 3) which influenced the sampling strategy. As such, the multiple realities which emerged during the preliminary work provided the focus for the main study rather than the researcher's own preconceptions (Lincoln and Guba, 1985). The use of a questionnaire to obtain information from which to select a purposive sample was a helpful technique. It was an approach used successfully in earlier research work (Appleton, 1993; Reed et al. 1996) and deemed to be potentially helpful in identifying possible sites for the main study.

Other factors were also important in identifying case study sites, including discussions with Senior Nurses at Health Visitor professional development conferences and telephone conversations with those who contacted the researcher

about the study. This latter point was undoubtedly influenced by the written feedback sent to all Senior Nurses who participated in the preliminary work (See Appendix 5.1). Senior Nurses played an important gate-keeping role, in potentially allowing access to study sites and in generating interest about the research amongst the local health visitors. Geographical location in terms of ease of accessibility was also another consideration. It is essential for a constructivist researcher to spend sufficient time in the case study sites to "*build rapport, develop trust, understand the culture, and obtain a sufficient amount of in-depth data*" (Erlandson et al, 1993:59) to increase the opportunity of developing shared realities with participants.

The analysis of the preliminary research data (Chapter 3) provided important information about the formal guidelines developed for use by health visitors to assist in the identification of families deemed to require additional support. Completion of this early work enabled the researcher to focus on those aspects that appeared most relevant to the main study. Chapter 3 raised a number of questions about health visitor professional judgement and the degree to which it is influenced by formal guidelines. Therefore in the main study, a purposive sampling strategy was adopted to identify four Community Trusts willing to participate, where different guidelines were issued to health visitors to identify vulnerable families. The researcher wished to explore the extent to which these guidelines influence health visitors' professional judgements in determining to increase support to families.

Purposive sampling is typically used in constructivist inquiry. It intentionally seeks out "*typical and divergent data*" (Erlandson et al. 1993:148) to maximise the breadth of information collected. Lincoln and Guba (1985) describe how this type of sampling strategy has a greater chance of uncovering the full range of multiple realities. It is very different to conventional sampling and is not based on statistical considerations, but on informational factors (Lincoln and Guba, 1985). The major concern of this research was not to generalise the findings to specific population groups, but to maximise the possibility of identifying patterns and relationships that exist in the particular contexts under study and which could help to illuminate the phenomenon of health visitor professional judgement.

In this study, a maximum variation sampling strategy was used to identify one pilot site, one Community Trust with no guidelines, one where fairly prescriptive guidelines existed and one where the guideline acknowledged the exercise of professional judgement in assessment. Patton (1990:172) describes maximum variation sampling as a strategy aimed "*at capturing and describing the central themes*" and unique variations which can emerge in an inquiry. According to Lincoln and Guba (1985:201):

> *the object of the game is not to focus on the similarities which can be developed into generalisations, but to detail the many specifics that give the context its unique flavour.*

Thus case sites were selected to be as different as possible in their adherence to formal guidelines to generate as much variety of information as possible. Constructivists believe strongly that context is critical and seek to identify the idiographic aspects of each case (Lincoln and Guba, 1985). Case study sites not only differed in terms of the types of guidelines in existence but were also quite diverse in their location, being situated in the North, Midlands and Southern regions of the country.

In summary, an emergent sampling design was used to identify the apparent significant characteristics and relevant focus of the study sites. The fact that all four study sites were selected at once could be criticised as Lincoln and Guba (1985) have suggested that the purpose of maximum variation sampling is most likely to be attained if sample units are selected and analysed serially. However, in view of the time constraints for data collection and the fact that a considerable length of time was needed to achieve access in some sites this was not deemed feasible. Furthermore the preliminary work appeared to have refined the focus of the study.

5.6 Issues of ethics

Ethical dilemmas can arise from the moment a research project is conceived and all researchers have an important obligation to carefully consider ethical issues when conducting research. Watson (1996:8) is very clear that inquirers must ensure that the research they are intending to undertake is clearly warranted and "*that the information*

being sought is not available elsewhere". The review of the literature for this study indicated that although a number of recent studies have attempted to examine 'needs assessment' in health visiting, research is still very much in its infancy. One issue appeared to be of striking importance, that clearer insights needed to be gained about health visitor professional judgement in identifying health needs and prioritising families requiring extra support through an analysis of observed practice rather than health visitors' reported perceptions of practice. Thus the researcher felt justified in initiating this research study, but clearly needed to be acutely aware of moral and ethical issues in seeking access to potentially vulnerable people.

It appeared from the start that a study exploring health visitors' work with vulnerable families was likely to be an area of considerable sensitivity. This is because many of these families are facing considerable health problems, social, emotional and/or financial difficulties. Lee and Renzetti (1993:4) define sensitive research topics as those "*that seem to be threatening in some way to those being studied*". They argue that while it is possible for any research topic to be potentially sensitive "*depending on context*" (Lee and Renzetti, 1993:6), there are a number of areas where research is likely to be more threatening.

These are :

- *where research intrudes into the private sphere or develops into some deeply personal experience*
- *where the study is concerned with deviance and social control*
- *where it impinges on the vested interest of powerful persons in the exercise of coercion or domination*
- *where it deals with things sacred to those being studied that they do not wish profaned.*

(Lee and Renzetti, 1993:6).

Conducting research with vulnerable clients who are living in highly stressful situations, can clearly be perceived as threatening and viewed as potential intrusion into deeply personal and private affairs. The researcher was acutely aware from her own experiences as a practitioner that she would need to tread particularly carefully,

honestly and diplomatically when accessing these groups. Scott (1996:7) has previously highlighted the fact that researchers "*have an additional duty of care to potential participants*" where peoples' ability for freely giving informed consent could be eroded.

The sensitive nature of the study became more apparent when during initial discussions with a research colleague, it was forcefully suggested that gaining access to 'vulnerable' clients would be impossible. Although initially alarmed, this did have the effect of making the researcher consider quite carefully the sort of terminology which health visitors and their managers routinely use to 'label' clients. These vulnerable families are sometimes referred to as high dependency, cause for concern, high risk or families 'in need'. Furthermore the use of terms such as 'vulnerable' and 'high risk' automatically makes gatekeepers very wary about the potential nature of research. It thus seemed advantageous to select another phrase to capture the focus of the research, to be both sensitive to clients' needs and to ease access arrangements. After much deliberation the phrase 'families requiring extra health visiting support' was selected as an umbrella term to encompass the range of family situations likely to present themselves during the course of the inquiry.

These included:

- Families with increased health needs
- Children in need (or with increased health needs)
- Children where there are child protection concerns – but where there is no evidence or not enough evidence of actual or potential harm, for the children to be regarded as children in need of protection.

Families with children currently on the child protection register or where there was currently a child protection investigation were excluded from the research.

Ethical issues are closely bound up with many stages in the research process, such as access arrangements to sites, sampling procedures and recruitment, data collection and management. Indeed in practice, it is difficult to separate these issues. As such ethical dilemmas and respect for participant autonomy through informed consent will

be addressed in greater detail in the following sections 'Issues of access to the natural setting' and 'Purposive sampling.' While the ethical concerns associated with the particular methods and data management strategies will be examined further in the relevant sections in this chapter.

5.7 Issues of access to the natural setting

To develop knowledge about health visitors' professional judgements, it seemed crucial to study health visitors at work with clients in their own settings. This is a fundamental feature of constructivist methodology. To examine health visiting in any other setting than its real life context would involve applying artificial constraints to practice and it would not be possible to achieve a 'true' picture of the reality of health visiting. Gaining access to research sites and respondents is an essential prerequisite for any inquiry. Yet as Burgess (1984:45) notes "*access is not a straightforward procedure*" and this was something that the researcher learned fairly quickly! Gaining access is not just a one off event, but a complex and lengthy process involving continual negotiation and co-operation (Appleton, 1997b). Fortunately the initial postal survey (See Chapter 3) certainly fulfilled the important function of enabling the researcher to identify and gain access to the main study sites.

5.7.1 Accessing gatekeepers

Having identified four case sites, access was negotiated through a series of gatekeepers. Gatekeepers are:

> *those individuals in an organisation that have power to grant or withhold access to people or situations for the purpose of research* (Burgess, 1984:48).

Community Trust Nurse Management

In all Trusts access to the sites was initially sought via the Senior Nurse who had responded to the preliminary postal questionnaire (See Appendix 5.2 for an initial letter of introduction). In one area, access to the site was exceptionally straightforward and granted immediately by the Senior Nurse. In two other Trusts, meetings were held with managers to discuss the study in more detail before access

was agreed. However, in one site, where several organisational changes were taking place, seeking access was more problematic.

In this Trust permission was initially granted to undertake the study following a meeting with the Senior Manager for Health Visiting and a date agreed for the researcher to meet with the local health visitors to discuss the study. However, shortly afterwards the manager transferred to another post, the meeting with the health visitors was cancelled and access arrangements had to renegotiated. This process involved liaising with another individual and meeting with a panel of nurse managers, before approval was finally given. It certainly demonstrated how persistence and diplomacy are required to ensure that access is negotiated correctly through hierarchical Trust structures. Gaining initial approval for the study in this Trust eventually took 4.5 months (See Appendix 5.3 for access approval letters).

Local Research Ethics Committees

The second group of gatekeepers to be approached were the Local Research Ethics Committees. Each committee required a different research proposal form to be completed, which in itself was a lengthy task (See Appendix 5.4 For Ethics Committees' approval). Lack of understanding by one Committee about the purpose and nature of qualitative research proved to be a major obstacle in gaining approval for the study in one case site. Generally this Ethics Committee had little awareness about health visitors work, particularly around the child health promotion aspects of the role. The researcher had to explain how it would be inappropriate for her to accompany health visitors for several days at a time, as many families would not be receiving 'extra support'. This would not only be wasteful in terms of researcher time, but could be an inconvenience to the health visitors, as well as being unethical to visit families who were not the focus of interest.

Health visitors

Once permission was granted from the Ethics Committees and from Senior Nurses the third group of gatekeepers were accessed. These were the health visitors working in the Trusts who were invited to attend a discussion meeting held locally where the

researcher described the proposed research. Health visitors were regarded as gatekeepers as the researcher was totally reliant on these practitioners in facilitating access to families receiving extra health visiting support. If the health visitor participants had not trusted the researcher then it is unlikely that access to this group of families would have been achieved.

Constructivist inquiry is highly interactive and the researcher often has to sell their personality and clinical credibility as part of the process of gaining access to study settings and participants. Experience would suggest that one has to be extremely tactful and continually sensitive throughout this process. Researchers need to ensure that enough information about the study is made available to all gatekeepers, as access will depend on the good will of these people.

5.8 Purposive sampling

When sampling the inquirer must consider a number of important issues including the purpose of the study, the research site, population, phenomenon of interest, time limitations, accessibility and financial resources (Patton, 1990; Marshall and Rossman, 1995). In constructivist inquiry the aim of purposive sampling is to "*include as much information as possible, in all its various ramifications and constructions*" (Lincoln and Guba, 1985:201). This inquiry has employed a number of sampling strategies to address the initial objectives. Sampling issues have already been discussed in relation to case site selection; this section will describe how the health visitor and client samples were recruited.

5.8.1 Health visitor sample

Initially in all case sites the researcher met with health visitors to give details about the proposed research. A volunteer sampling strategy was used to purposively select health visitors to participate in the study. In the pilot site following this discussion meeting a letter was posted to all health visitors employed in the Trust (See Appendix 5.5 for copy of the letter). This letter reiterated the nature of the research project and invited participation in the study. Health visitors were invited to return a tear off slip in an SAE stating whether or not they would be willing to participate. From the

replies, volunteer sampling was used to identify health visitors willing to participate in the accompanied home visits and in-depth interviews. As the aim of the research was to elicit rich qualitative case data, it seemed important to select participants who appeared, from this initial response to have interest in the issue under investigation.

Volunteer samples are used in research when potential respondents are unknown to the inquirer (Morse, 1991) but where they are willing to participate and talk to the researcher. Volunteer samples consist of participants who have experienced a phenomenon and who offer to share their experiences and insights (Sullivan, 1996). The researcher believed that all qualified health visitors would have some expertise in making judgements about families needing extra support. However, in view of the potentially sensitive nature of the accompanied home visits the researcher felt it was most appropriate to select a health visitor sample who seemed receptive to the research. Health visitors were thus selected on the basis of perceived co-operation, their potential contribution to increasing understanding about the concept of professional judgement and that they were willing to be accompanied on home visits to families being offered extra support. The researcher determined that these practitioners would be able to offer a variety of constructions to develop understanding about the nature of professional judgement. At such an initial stage of inquiry, it would have been illogical to select respondents who had no interest in the study as it is unlikely that the aim of the accompanied home visits would have been achieved (Morse and Field, 1996).

Volunteer sample selection was also influenced by two other factors. In the main study areas the inquirer sought help from the Senior Nurse to provide extra information about the nature of health visitor caseloads, degree of deprivation in their areas of work etc. Another factor, which was also significant in determining sample selection, was the degree of rapport that the researcher built up with individual health visitors either during the initial meeting or later through telephone discussions.

Volunteer samples can however be criticised for being biased towards selection of respondents who can articulate their practice. However, this was an essential pre-

requisite of this study, thus the findings are written in a tentative manner which reflects the initial study objectives, to seek an explanation of how health visitors in three contrasting case study sites make judgements about families in need. The study findings present a detailed interpretation of these health visitors' knowledge of and application of assessment practices. The study has not attempted to illustrate what health visitors are doing beyond the immediate study contexts, or to determine the incidence of specific characteristics throughout a given population.

In the pilot study three health visitors participated in the accompanied home visits and interviews. The strategy for selecting health visitors was refined following insights gained during pilot work. In one Trust, all 47 health visitors were contacted by letter to determine their interest in taking part (See Appendix 5.6 for copy of letter to health visitors). This was because, although a preliminary discussion meeting with health visitors had been held in March 1996, six months elapsed between that meeting and approval being gained from the Ethics Committee. In the other main study sites, health visitors were requested during the initial group meeting to leave their name and contact phone number if they were interested in taking part in the research.

The process of volunteer sample selection then involved the researcher phoning interested practitioners to explore if they were still keen to participate and to answer individual queries. Munhall (1988) highlights the "*on-going process*" of seeking consent from potential respondents. She states that "*informed consent is a static past tense concept*" (Munhall, 1988:151) and that in qualitative research which is emergent and continually changing, consent is not a one off event but needs to be continually negotiated and agreed. Once initial verbal agreement to participate was reached with each health visitor, they were sent a formal letter of invitation outlining the study and the expected nature of their involvement (See Appendix 5.7 – Formal letter of invitation). It allowed the health visitors further time to reflect on their decision to be involved.

In the main study, a volunteer sample of five health visitors from each of the three case sites was selected to participate. Once a sample had been identified another

meeting was held to address issues around data collection, tape recording, gaining informed consent from clients and ethical issues (UKCC, 1992). Written consent was gained from all health visitors (See Appendix 5.8 – Health Visitor Consent Form). One health visitor participated in an initial interview and then chose to withdraw from the study after several cancelled visits. On reflection, one of the advantages of the human investigator as data collector, is that a very proactive stance can be adopted in building up a level of trust and rapport with potential respondents; although as my diary entry indicated my efforts with this health visitor were clearly unsuccessful.

5.8.2 Client sample

It was planned that all clients to be involved in the study would be selected by their health visitor as caseload manager. The criteria for selection was that clients were currently receiving an increased level of input from their health visitor (as defined by the health visitor) and would be agreeable to participate in the study (to be observed and later interviewed by the researcher). Because of the sensitive nature of the research, it was deemed important that the health visitors maintained control over the 'selection' of clients taking part. A nominated or snowball sampling approach was therefore utilised. This is when an informant "*is invited to suggest another participant, and the researcher uses this referral to solicit the second person to be a part of the study*" (Morse, 1991:130).

The benefit of this sampling strategy is that it may be the only way to reach the group of interest, in the case of this study, families who were receiving extra support from the health visiting service. Furthermore, the nominated sampling technique was also helpful in developing "*researcher - informant trust*" (Morse, 1991:130) in that the health visitors tended to introduce the researcher to their clients in a positive light. Care had to be taken to ensure that the researcher/health visitor relationship was maintained at a professional level at all times, to avoid being collusive in nature. This was important to ensure that clients did not feel coerced into participating and gave their full and informed consent.

Health visitors were requested to satisfy themselves that the clients fitted the study criteria and would be happy to participate. Initially health visitors had concerns about who to ask to take part, often feeling they needed to tread carefully as they were concerned about damaging established client relationships by having another person present. Inevitably some clients declined to take part. However on several occasions when health visitors had tentatively approached clients whom they thought would refuse to participate, the clients agreed to take part, much to the practitioners' surprise.

At one of the initial meetings one health visitor had expressed concern that families may not always know they are being given extra support. This was something that the researcher had concerns about, but in practice was not an issue. Both the client information sheet and consent form clearly stated the focus of the study (See Appendix 5.9 for Client Information Sheet) and the researcher discussed this with families on arrival at the home. It did however provide an interesting discussion topic in the practitioner interviews.

In qualitative research the sample has to be large enough to demonstrate "*informational redundancy*" (Lincoln and Guba, 1985:202) and small enough to undertake an in-depth "*case-oriented analysis*". Sandelowski (1995:183) states that this is largely a matter of personal judgement, but stresses that the sample should be large enough to result in "*a new and richly textured understanding of experience*". Altogether 56 clients participated in the observed home contacts and 53 took part in separate interviews providing a rich information source.

5.9 Instruments

5.9.1 Researcher as instrument

In constructivist inquiry the human researcher is regarded as the primary data collection instrument and is therefore highly instrumental in ensuring the progression of an effective inquiry (Lincoln and Guba, 1985). This approach requires the investigator to be both proactive and responsive. Guba and Lincoln (1981:131) suggest that only human research instruments have the attributes to deal effectively with ambiguous and complex situations, as they are "*infinitely adaptable*". A key to

the successful progress of this study was the researcher's responsiveness to people and contextual cues. Humans have the ability to process information immediately and can respond to data by seeking further clarification from a participant or by exploring peculiarities to achieve further understanding. It is hoped that a depth and richness of data was achieved by the researcher developing honest and respectful relationships with participants.

5.9.2 Data collection instruments

A common feature of case study research is its adoption of multiple methods of data collection. Multiple methods have been utilised in this research for a number of reasons. Data from preliminary research work and the literature indicated that health visitor professional judgement is likely to be an extremely complex and multifaceted issue. Indeed health visitors' may draw on different factors and ways of knowing when making an assessment that a family needs extra support. By integrating different methods it was hoped to explore the various elements of professional judgement to provide detailed explanations of this phenomenon. As Erlandson et al (1993:138) state, on its own a single method is unlikely to advance understanding about a phenomenon unless "*enriched through triangulation.*" By combining several data gathering techniques a richer, deeper and more comprehensive understanding can be achieved, as the strengths and limitations of the different methods are counterbalanced to add rigour, breadth and depth (Patton, 1990; Denzin and Lincoln, 1998). The primary aim of data collection in constructivist inquiry is to discover participants' constructions.

Seven data sources (Table 5.2) were included in the study:

- an initial tape-recorded interview with the health visitor
- an informal discussion with the health visitor immediately prior to each home visit recorded in field note form
- field notes of each observed visit
- an audio-recording of each home visit.
- a tape-recorded interview with the health visitor following each visit
- a tape-recorded interview with each client after the visit
- diary – a log of researcher contacts with the case sites.

Table 5.2: Data Sources

Initial Interview with Health Visitor (Sometimes with first post-visit interview) →	Background interview with HV, general issues explored around their conceptualisation of professional judgement,assessment processes and families requiring increased support.
Pre-home visit interview with Health Visitor (field notes) →	Informal discussion with HV prior to home visit to elicit background information about the family and visit objectives. These notes have been combined with the transcription of the HV interview conducted post home visit.
Field notes on observation schedule →	Re-typed after each visit, additional field notes recorded following home visit. Contains context observations and notes on significant actions/events during the observed visit.
Tape-recording of observed home visit →	Transcription of tape-recorded home visit. These have been combined with observation field notes.
Tape-recording of Health Visitor interview post visit →	Transcription of interview focusing on observed home visit. These data have been combined with notes made during the informal interview with the health visitor prior to each home visit.
Tape-recording of client interview post visit →	Transcription of client interview.
Research diary →	A log of daily contacts with the research sites, consisting of researcher thoughts, reflections and insights about about, for example,access issues.

The following sections will describe how the instruments were developed through pilot work and provides the 'decision trail' (Sandelowski, 1986) to main study data collection. They are described in order of use in the research.

5.9.3 The initial health visitor interview schedule (Part A)

An initial interview was conducted with each health visitor either prior to the first observed home visit or immediately following it to explore general issues around professional judgement and client assessment. Kvale (1996:5) describes a research interview as a professional conversation and interaction "*to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomena.*" He suggests each interview will have a structure and purpose and that interview topics will be guided by the researcher (Kvale, 1996).

Collecting data through an interview has several advantages, for example high response rates are common and the human instrument is able to facilitate an

interactive and informal approach to data collection. Control of the interview process lies with the interviewer who can put the respondent at ease through sensitive questioning and by effective interpersonal skills. Ambiguous or unclear questions, which may be misinterpreted by respondents, can be clarified or rephrased. Interviews also allow the use of open questions that can encourage respondents to expand on their experiences and often result in a rich data source (Cormack, 1996; Polit and Hungler, 1999).

However, interviews are not without limitations (Burns and Grove, 1997). They are costly to conduct, time consuming both in terms of arranging and travelling to the interviews and the length of the interview. Interviews take a tremendous amount of time to transcribe, code and analyse. The quality of the data generated is largely dependent on the skill and expertise of the interviewer as research instrument (Guba and Lincoln, 1991). However, quality can be enhanced throughout the interview by the researcher clarifying understanding about the meaning of what has been said by the respondent and by verifying his/her interpretation of responses (Kvale, 1996).

A semi-structured interview schedule was designed specifically for the study, which provided a guiding framework of issues to be explored in the interview (See Appendix 5.10 – Health Visitor Interview Guide 'Part A'). Swanson (1986:66) cites Lofland (1971) who defines the purpose of this type of interview is to gather "*information in the respondent's own words, to gain a description of situations and to elicit detail.*" This initial health visitor interview, referred to as 'Part A' had several purposes. Firstly to gather general background information about each health visitor's training and employment history. Secondly it facilitated an in-depth exploration of health visitors' conceptualisations about professional judgement and assessment processes. It was intended that the interview questions would probe the skills and sources of knowledge used in such assessments. A third aim was to seek contextual information and detail about each Trust's service philosophy. The inclusion of a question about the impact of guidelines on assessment was deemed important in view of the preliminary findings in Chapter 3. Finally, the schedule attempted to elicit health visitors' views about the nature of increased family support.

Developing the initial health visitor interview schedule – Pilot work

The interview schedule was developed through pre-pilot work and its content refined through discussions with two experienced researchers. Alterations centred on making the opening questions as unthreatening as possible. The schedule was planned so that initial questions were fairly straightforward, before moving onto potentially difficult and thought provoking questions later. Pilot interviews were undertaken in 'Site D', with three health visitors. These pilot interviews proved exceptionally helpful in enabling the researcher to gain confidence in interactive interviewing, as well as gaining practical familiarity with the interview schedule. The literature highlights that rich data will only be gathered by asking carefully worded, good questions and through diligent listening and recording (Erlandson et al, 1993; Kvale, 1996).

Initially it had been planned to explore Parts A and B of the interview schedule within the first health visitor interview, but logistically this meant that this interview was often extremely lengthy. To overcome this problem, the interview schedule was split in two and where possible, these interviews were conducted separately.

Data collection - The initial health visitor interview

Initial exploratory interviews were conducted with the fifteen participating health visitors, between September 1996 and March 1997. Provisional dates for the interviews and accompanied home visits were agreed with the health visitors during the discussion meetings described earlier and a letter confirming these dates sent to each participant (See Appendix 5.11 - For letter confirming accompanied visits). Data collection took place at the health visitor's base in an office or other available room. All initial interviews were audio recorded and data confidentiality reiterated.

5.9.4 The pre-home visit interview guide

An informal discussion took place with health visitors immediately prior to each visit to elicit background information about previous health visitor contact with the family. An outline framework designed to be very specific, which was attached to the front of the observation schedule as a facesheet, guided this informal discussion (See Appendix 5.12 - For copy of facesheet and observation record). Morse and Field (1996) advocate

using this technique when the researcher is clear about the data needed. During this short pre-visit interview the researcher explored the reason for the family receiving increased support. This provided contextual information to aid understanding about the reasons for health visitor contact with the family. In view of the potential complexity of some family situations, it was deemed extremely important for the researcher not to be 'going in blind' to the observed visits. Objectives for the planned contact were also elicited, to enable later comparisons. Data were recorded in field note form on the standardised facesheet.

Developing the pre-home visit interview guide – pilot work

Pilot work provided a useful opportunity to examine how effective the standardised interview guide was in gathering essential pre-visit data. No alterations to the structure of the interview guide were made following pilot work.

Data collection – The pre-home visit interview

Sixty pre-home visit interviews were conducted with health visitors, however four data sets were not analysed as they accounted for no access visits and no further data were collected. The pre-home visit interview combined with other data sources to provide a more robust understanding of why a particular family was receiving increased health visitor support. It also offered an opportunity to seek clarification about the purpose of the planned client contact prior to the accompanied visit.

5.9.5 The observation schedule

Observation is commonly used when data is sought about people's actions and behaviour, their communication (both verbal and non-verbal), skills acquisition, events and the social environment (Polit and Hungler, 2000; Marshall and Rossman, 1995). It can range from a highly structured technique using categories and checklists to a "*more holistic description of events and behaviour*" (Marshall and Rossman, 1995:79). In constructivist inquiry observation typically takes place in the natural setting, it is unstructured and the researcher adopts a participant observation role. Participant observation is "*a method of data collection in which the researcher is actively engaged in the situation being observed*" (Couchman and Dawson, 1990). Its aim is to generate insights into the realities of people's daily lives.

Burgess (1984) describes four participant observation roles:- complete participant, participant-as-observer, observer-as-participant and complete observer. During home visits the researcher adopted the role of observer-as-participant to observe the health visitor/client interactions. The researcher fully disclosed her role to all participants and by her very presence at home visits was peripherally involved in the study context. For example, one health visitor while positively reinforcing a mother's budgeting skills, attempted to involve the researcher in her discussion, furthermore young children often approached the observer through curiosity, touching and speaking to her, one even tried to gain her attention by throwing a 'Pringles' box at her! However, as far as possible participation was kept to a minimum and the researcher attempted to maintain a detached role, keeping in the background wherever possible.

There are a number of advantages to adopting observation in constructivist inquiry. The researcher can observe behaviour or events taking place as they occur (Guba and Lincoln, 1981), thus enabling a better understanding of the phenomenon of interest in its natural context. As Marshall and Rossman (1995:79) note:

> *through observation, the researcher learns about the behaviours and the meanings attached to those behaviours. This method assumes that behaviour is purposive and expressive of deeper values and beliefs.*

It is a useful strategy for gaining direct experience of complex interactions, which can complement the reported and selective perceptions of interviewees (Patton, 1990). It enables data to be gathered which would be impossible to collect in other ways and "*allows the inquirer to see the world as his subjects see it*" (Guba and Lincoln, 1981:193). Unstructured observation is a flexible approach that enables the researcher to concentrate on those variables or issues which appear important so the researcher is able to uncover recurring patterns of relationships and behaviour (Marshall and Rossman, 1995).

The disadvantages of unstructured observation are well documented. The main concern surrounds the extent to which the observer affects the study context, influencing participants' behaviour and interfering with the validity of findings

(Robson, 1993; Morse and Field, 1996). The researcher attempted to overcome this problem by visiting with the same health visitor over a period of at least four home visits, so that each practitioner became accustomed to her presence. Robson (1993) however, is critical of this approach arguing that it is impossible to know what people's behaviour would have been like if they had not been observed. Furthermore, the researcher was always a stranger to participating clients. It is likely though, that if the health visitors were comfortable with the researcher's presence, they would behave in a fairly normal manner with clients. The researcher attempted to address this issue in the client interview by exploring whether the presence of a third party appeared to alter the health visitor's 'usual' behaviour.

Conducting observation in natural settings is time-consuming and observers have little control over extraneous variables that could influence study data (Bailey, 1982; Polgar and Thomas, 1995). Access may not be easy, it can sometimes be difficult to gain approval to undertake observation studies and there may be ethical considerations to address (Bailey 1982). Researchers have highlighted the role conflicts facing nurses when as researcher/observer they witness unacceptable practice (Buckingham, 1996). As the method relies on the personal interpretations of the observer, the researcher may be influenced by prejudices, assumptions and other pre-conceived ideas. The more reliance on observer inference, the greater the risk of bias and "*going native*" (Guba and Lincoln, 1981:193). Loss of observer objectivity can occur as the observer becomes too close to the participants and fails to notice certain things (Bailey, 1982).

Further difficulties associated with this method are the fact that it often yields considerable amounts of data which can be difficult to record, categorise and code (Bailey, 1982). Reliability and validity of observation data is influenced by the degree of adequacy of the data collection methods, for example the appropriateness of the coding schedule and the length of the observer's attention span. Furthermore "*observation aids and recording equipment may be more difficult to use*" in the natural setting (Polgar and Thomas, 1995:152). It is clearly impossible to observe and record everything, so researchers adopting unstructured observation techniques have

to make decisions about data selectivity and what they are looking for (Guba and Lincoln, 1981; Mason, 1996). "*Observations are also limited in focusing only on external behaviours*" (Patton, 1990:244).

In unstructured observation, field notes (jotted notes written inconspicuously during the observation period), provide descriptive observation data and a record of events as they occur (Lofland and Lofland, 1995). However Bogdan and Taylor (1975) are critical of the use of field notes, arguing that note taking can influence the behaviour and confidence of those observed. In this study consideration was initially given to adopting a structured observation schedule, but this was clearly inappropriate as the researcher was unclear about the potentially significant elements in the health visitor/client interaction. She was wary about adopting a structured schedule and imposing her own preconceived interpretations on the study context, possibly missing something significant in the interaction. Indeed Bergen et al (1996) found that community nursing assessment did not adopt a structured chronological approach. The researcher determined that significant happenings may occur during the visits that she would wish to follow up in the interviews. Thus she adopted an unstructured approach which as Silverman (1993:31) notes "*increases the possibility of coming across unexpected issues.*"

The purpose of this study was to gain first-hand information about the processes involved in health visitor professional judgement. The focus was therefore on what health visitors do and say during client contacts, not on what they thought they did (Silverman, 1993). As a concept it was unlikely that professional judgement could be observed. Instead the researcher was concerned with observing context, behaviour and how things were said. As Merriam (1988) and Patton (1990) advised, the researcher compiled a list of factors that may be significant in influencing the health visitor/client interaction and therefore impact on judgement processes. These "*sensitising concepts*" are used to "*provide a basic* [observation] *framework highlighting the importance of certain kinds of events, activities and behaviours*" (Patton, 1990:216). The final observation schedule consisted of a blank sheet with the following "*sensitising concepts*" at the top, which provided a framework for examining the context of health visitor/client interactions:-

The setting	To include a description of who was present during the observed visit. This was important as often the health visitor was not making an assessment of one client in isolation, there were frequently others present. In some situations people came and left during the observation period. This term also prompted observation of the physical environment of the home and surrounding area, as well as physical facilitators and constraints in the interaction.
Interpersonal	This prompted the observer to consider health visitors' use of interpersonal communication and behaviours in gaining knowledge about the current family situation. In view of Kendall's (1993) findings that health visitors were extremely controlling in their interactions with clients and did not promote participation, it facilitated consideration of whether communications were open or closed. The use of formal guidelines was also considered.
Issues/Significant events to be raised in the interviews	This prompt identified significant issues to be raised in the post-visit interview. It provided the opportunity to later check things out, either to clarify why the practitioner said or did certain things or to explore the researcher's own understanding of the situation. It offered the researcher the opportunity to draw on her own professional experience and to explore issues that she might have expected to have occurred, as well as examine any 'unusual' circumstances. It also alerted her to evidence of health visitor judgement(s).

Developing the observation schedule – Pilot work

Despite the final observation schedule being extremely simple in design, it did take considerable time and thought to develop. Preliminary ideas for the construction of the draft schedule centred on the study setting, health visitor assessment skills, use of formal guidelines and health visitor knowledge base. However, through pre-pilot work and discussions with another experienced researcher, it became clear that large numbers of "*sensitising concepts*" and the fine detail this generated was not manageable and that a one page recording sheet seemed most practical.

Through pilot work the researcher began to recognise the significance of the observation schedule providing only one piece of the jigsaw. Instead observations

were to prove complementary to subsequent interviews in building understanding about the phenomenon of professional judgement and enriching the emerging constructions. Seeing the client/health visitor interactions 'in the flesh' provided first-hand data about social processes and on several occasions observations indicated probes for post-visit interviews.

Pilot work also provided an opportunity to explore how the observations would be recorded and logged in field note form. Several different layouts of the observation record sheet were piloted before opting for the one page record sheet. This stage proved extremely helpful in modifying the observation schedule and producing a recording sheet to jot on fairly inconspicuously.

Data collection – The observation schedule

Fifty-six home visits were observed over a period of 12 months to examine the interaction between health visitor and client[s] and to explore assessment processes. Twelve health visitors were accompanied on 4 home visits each, one health visitor on three home visits and one on five. Provisional dates for the visits were agreed with the health visitors during the participant discussion meetings and a letter confirming these dates sent to each (See Appendix 5.11). In practice these visit dates frequently needed to be renegotiated to fit in with health visitors' changing work plans. An advantage of the human instrument was the flexibility this allowed in being available to accompany health visitors at short notice on visits to vulnerable clients.

On a few occasions health visitors had arranged visits with the researcher but then a few days before a child protection incident occurred, so the families no longer fitted the study inclusion criteria. Although disappointing, it would certainly have been unethical to include these families in the study, when families were in crisis and where parents were subject to child protection investigation. A small number of 'no-access visits' were also encountered.

Prior to the accompanied visit, health visitors were requested to discuss the study (including the proposed observation and tape recording of visits) with the selected

clients to find out if they were interested in participating. If the client agreed to participate, the health visitor sought the client's preliminary verbal consent and a date was arranged for the health visitor to make a home visit accompanied by the researcher. (This was not an additional home visit, but a visit as part of the agreed client/health visitor contract.) Ensuring preliminary verbal consent was important otherwise clients could have been intimidated by the arrival of an unannounced 'researcher'. In terms of the health visiting workload it was deemed most appropriate to seek preliminary verbal consent as any other arrangement would have resulted in health visitors having to make additional visits to clients. It also allowed the client some time to reflect upon their agreement to participate and enabled them to change their mind if they so wished before the visit.

Health visitors were asked to give an information sheet to clients which outlined the research (See Appendix 5.9 – Client Information Sheet). This information sheet emphasised that clients should not feel obliged to participate and gave reassurance about rights to withdraw. In practice health visitors did not always send the Information Sheet to clients beforehand and this had to be given to the clients at the accompanied visit and time allowed for them to read through it. This reinforces the view previously described that gaining informed consent is an on-going process, which must be continually checked as a study progresses.

On arrival at the client's home and right at the beginning the researcher sought written consent from the client to observe and record the visit (See Appendix 5.13 – Client Consent Form). However, as Scott (1996:11) has pointed out the extent to which clients' are fully aware that they are also giving "*permission for their home and their interactions to be observed*" could be open to question. After the client had agreed to participate an information sheet about the study was, with the client's permission forwarded to their General Practitioner by the health visitor as a matter of courtesy. (See Appendix 5.14 – GP Information Sheet). No client surnames or addresses were recorded on the observation record sheet. Following each period of observation, field notes were typed into a word-processing file, fully anonymised and original recording sheets destroyed.

5.9.6 The audio-recording of the home visit

As well as recording observation data through field notes, accompanied visits were also audio-recorded. This technique has been used successfully by other researchers studying health visitors' interactions with clients (Sefi, 1988; Kendall, 1991). The rationale for using a form of electronic recording was multi-purpose and included the fact that both the audio-recording with subsequent transcripts provided a more complete record of the visit for analysis purposes. Such level of detail would be impossible to capture using field notes alone and thus contributes to the overall robustness of the data. This recording forms a permanent record which can be "*... listened to repeatedly in cases of doubt about interpretation*" (Guba and Lincoln, 1981:203). Audio-recordings proved particularly helpful in very complex family situations, where so much was happening that something crucial could easily have been missed. To have such a recording is also a useful back up if the observer's attention span begins to wander.

Furthermore the recording and subsequent transcript offered the opportunity during data analysis to examine the assessment processes and strategies adopted by health visitors and the particular sequencing of events across each of the four visits. This would have been impossible if only reliant on field notes or inaccurate memories

However, as Mason (1996:53) points out:

> *a transcription is always partial partly because it is an inadequate record of non-verbal aspects of the interaction (even if you try to insert these in the form of fieldnotes into the transcription afterwards [which was attempted]), and also because judgements are made (usually by the person doing the transcription) about which verbal utterances to turn into text, and how to do it.*

The audio-recording and transcription complemented the researcher's own observations and interpretative field-notes. It enabled checks to be made on details reported during health visitor interviews. The transcribed and recorded data also provides an accessible and verifiable record for audit trail purposes.

Audio-recordings though are not without their critics. Indeed, Bogdan and Taylor (1975) are particularly sceptical about the use of tape-recording in the field because of the potential influence on study participants. These researchers argue that "*the goal of the researcher is to minimise the effects of his or her presence*" (Bogdan and Taylor, 1975:64). Guba and Lincoln (1981) also draw attention to the potential costs of audio-recording and the time commitment involved in subsequent transcription. Another potential limitation of this method and a problem encountered is that of equipment failure, therefore fieldnotes can provide an essential alternative data source. Mason (1996) also warns against the dangers of the observer failing to listen or stop watching, as he/she becomes over reliant on the tape recorder.

As the researcher intended to audio-record interactions in the home context, where participants were likely to move around during the course of a visit, the recording equipment needed to be able to cope with this variable. A radio microphone was considered an appropriate choice. Radio microphones have been used effectively by researchers in hospital settings, although the researcher found no evidence of this approach being adopted in clients' homes (Macleod Clark, 1982; Whyte and Watson, 1998).

Technical support engineers from a company specialising in audio equipment provided advice on wireless transmission. However concerns arose from the fact that radio microphones and stereo mixing devices require supply from mains power which was not practical in the home environment. Optimal reproduction is achieved through the use of two sets of transmitters and receivers, one for the health visitor and the other for the client, yet this had to be abandoned because of the need to avoid using power supplies in clients' homes. The only alternative option was to use one transmitter and receiver, and a single recording channel. (See Appendix 5.15 for diagram of wireless transmission).

The recording equipment consisted of :

- a lapel microphone attached by a recording wire to a transmitter and activated by a switch on the transmitter
- a slimline transmitter powered by batteries clipped onto a waistband or placed in a pocket
- a pocket-sized battery operated receiver, activated by a switch, with an antenna input connector on top and options to use either a helical whip or quarter-wave wire antenna. Maximum performance and range was gained by using the quarter-wave wire antenna
- an audio output lead with a five pin connector attached to a microphone input lead, connected the receiver to the battery operated cassette recorder.

Testing the audio-recording equipment – pilot work

Pre-pilot work involved intensive familiarisation with the recording equipment and testing of sound transmission ranges and quality. To ensure recording equipment was as unobtrusive as possible, the receiver and cassette recorder were kept in the researcher's bag during home visits. Once the transmitter had been placed inside the health visitor's pocket or waistband only the lapel microphone was visible. In the home situation this battery operated radio microphone proved to be the ideal solution where complete freedom of movement was required and where a mains powered receiver could not be used.

Before data collection, all health visitors met with the researcher. This offered the opportunity to instruct health visitors in the use of the microphone and enabled them to become familiar with the recording equipment. Five pilot home visits were recorded, which proved a learning exercise for all concerned. As time progressed the researcher became more confident and skilled in managing the recording equipment efficiently. Health visitors initially commented on feeling self-conscious about the lapel microphone and were anxious about its effect on clients, however this was soon forgotten. Clients also commented that they soon ignored the recording device, generally not finding it inhibiting.

Data collection – Audio-recording home visits

On arrival at the client's home, written and verbal consent was sought from the client to audio-record the visit. Although 56 home visits were conducted only 52 were

effectively recorded due to malfunctioning equipment. A further three recordings were difficult to hear, one due to static, in another the client spoke very quietly and a washing machine was spinning in the background, in a third there was a lot of indistinct and simultaneous speech. In 53 (94.64%) visits children were present and in 20 (25.71%), additional adults, other than the mother were present. This raised ethical issues in terms of consent and if children were present, clients were made aware of the fact that children's voices and play sounds would be recorded as part of the 'background visit noise'. If two parents were present, consent was sought from both and if anyone arrived during the visit they were made aware of the recording.

5.9.7 The post-visit health visitor interview schedule (Part B)

Following each visit health visitors were interviewed using an interview guide which is illustrated in Appendix 5.10 (Part B). The interview focus was the accompanied visit and the aim was to explore the health visitors' judgement in identifying health needs and offering the family increased support. Through these in-depth interviews the researcher intended to gather insights into the perspectives and constructed realities of the health visitors (Erlandson et al, 1993), by exploring cues and significant events from the home visit. It was intended that interview questions would probe the health visitors to provide a rationale for their actions during the visit.

In view of the preliminary research work, comparisons of 'checklist/guidelines' versus 'health visiting assessment process' were explored. Interviews supplemented observation and audio-taped data in their ability to expand and clarify practitioner meanings about professional judgement. Interview data also compensated for the weaknesses of observation methods, by gathering information about health visitors' knowledge levels and their attitudes, perceptions and awareness of what had occurred during the visits (Patton, 1990). This process elicited detailed insights into health visitors' cognitive processes. Furthermore the interview sought to explore health visitors' perceptions about clients' awareness that they were receiving extra support and if the health visitor had directly addressed this with them. This generated useful comparative data for when the clients were later interviewed.

Building on earlier work, the interview schedule sought to facilitate an in-depth exploration of six areas (See Appendix 5.10 – Health Visitor Interview Schedule 'Part B'):

- health visitor assessment processes
- perceptions of increased family support and intervention
- additional support networks and services
- exploring professional judgement and use of formal guidelines
- relationships with the client(s)/family
- reflection on visit.

Developing the post-visit health visitor interview schedule – Pilot Work

The post-visit interview schedule was developed through pre-pilot work and its content refined through discussions with two heath visitor researchers. Minor alterations were made to the schedule layout to make it more logical and clear. Pilot interviews were undertaken in Site D and were conducted with two health visitors following accompanied home visits. Pilot work enabled the researcher to recognise that a better understanding of health visitor assessment processes could be gained by asking interviewees to reflect on the assessments they had made during the visits, rather than focusing solely on judgements made. The interview schedule was thus developed accordingly.

Data collection – The post-visit health visitor interview

Over a twelve month period, fifty-six post-visit interviews were conducted with the fourteen health visitors who participated in the accompanied visits. The interviews were audio-recorded and they took place in a variety of settings, including the health visitor's car, office or a room in a doctor's surgery, clinic or health centre. Where possible the interview was conducted immediately following the visit or later the same day. Where this was not possible the interview was arranged as soon as possible, at the health visitor's convenience. Where there was a time lag between the observed visit and the interview, the researcher listened to the audio-recording and re-read her field notes to refresh her memory about the visit.

5.9.8 The post-visit client interview schedule

Following the observed visit, clients were contacted again at home and interviewed. An interview schedule was developed (See Appendix 5.16) to explore their thoughts about the home visit, their own health needs and how they perceived the health visitor's role. This seemed particularly pertinent in view of the government's focus on providing a consumer oriented service, which reflects expressed needs (Dept. of Health, 1998b). The client interview schedule focussed on the following areas:

- participant background information
- thoughts about the health visitor role
- relationships with own health visitor
- perceptions of family health
- thoughts about the observed home visit
- client perceptions about increased support
- service provided by health visitor
- help received from other agency/person.

Client interviews were conducted to supplement observation and health visitor interview data. Their function was to elicit client views about the health visiting service and the accompanied home visit. This was an opportunity to gather material to compare professional versus client perspectives about the nature of increased family support. This seemed important in determining the value of the health visiting service from a client perspective.

The post-visit client interview schedule – Pilot work

The post-visit client interview schedule was initially developed through pre-pilot work and through discussions with experienced researchers. Five pilot interviews were undertaken to refine the structure and content of the interview guide, and to enable the researcher to gain confidence in interviewing clients in the home environment. The researcher played an important role in putting clients at ease through friendly and informal discussion before the interview commenced. Indeed Waddington (1995:109) has stressed the need for researchers to "*concentrate on maintaining a positive and non-threatening self-image*" when interviewing.

At this stage the confidential nature of the discussion was emphasised. However, at the beginning of each interview, the researcher reiterated her own moral and professional obligation to children, that there were limits to confidentiality and that she would not ignore a case of reported child maltreatment (UKCC, 1992). In practice, tape-recording the client interviews was unproblematic, clients soon forget about the tape recorder, with only a small boundary microphone visible.

Data collection - The post-visit client interview

By seeking clients' perspectives on the home visit, this study has addressed an area which has been neglected in earlier studies. It certainly seemed important when examining health visitors' judgements about extra support, to consider the client perspective and the perceived impact of extra health visiting. Over twelve months, fifty-three client interviews were conducted. All took place in either the client's home or that of a friend or relative. The interviews were conducted where possible on the same day as the observed visit, or at the client's earliest convenience. In constructivist inquiry the researcher is constantly reminded of the need to be adaptable to the research demands. Arranging interviews was not always easy, on several occasions extra journeys were organised to visit the client and occasionally clients forgot about these pre-arranged visits. The researcher thus spent a lot of energies building rapport, developing a level of trust with participants and was as flexible as possible in making arrangements for follow-up visits with clients. Appendix 5.17 shows an excerpt from the researcher's diary that illustrates some of the frustrations experienced and perseverance required.

Three clients were not interviewed, two because of their failure to keep appointments despite 2-3 attempts to follow them up and no access visits. The researcher regarded this as an indication that the clients had decided not to participate further in the study. Another client disappeared with her partner, a known drug dealer and despite a mobile phone conversation with the client, follow-up was never achieved.

Interestingly, as Oakley (1981) and Finch (1993) found, most participants, including their male partners were keen to talk to me. Many were extremely hospitable, offering drinks and other refreshments. Having previously visited with the health visitor, this

certainly seemed to break the ice and I was no longer regarded as a stranger, but invariably welcomed into the home. Indeed some clients felt honoured that their health visitor had invited them to participate in the research and regarded themselves as a 'special case'. One mother even contacted the health visitor after our interview to find out if I would be returning to listen to her again. The therapeutic nature of such encounters is perhaps not always apparent.

5.9.9 Research diary

The research diary consisted of a log of contacts with study sites, recorded in a word processing file. Here my thoughts, feelings and questions were recorded as access and data collection progressed. This record was extremely helpful in reminding me about particular incidents and provided an enriched personal view of case study site contexts. It offered an abstract picture bringing memories to life and provided an audit trail justifying actions in the study's progress. As Rossman and Rallis (1998:43) comment "*documenting your intellectual and methodological journey is crucial for establishing the soundness of the study.*"

5.9.10 Data collection summary

Table 5.3 illustrates the data collected during the main study

Table 5.3: Data collected

Initial Interview with HV	→	15 in-depth interviews
Pre-home visit interview with HV (field notes)	→	60 (including 4 relating to no access visits where no further data were collected)
Field notes on observation schedule	→	56 sets of field notes
Tape-recording of observed home visit	→	52 visits recorded + (4 visits not recorded due to malfunctioning equipment)
Tape-recording of HV interview post-visit	→	55 post-visit health visitor interviews recorded + (1 interview not recorded due to malfunctioning equipment)
Tape-recording of client interview post-visit	→	50 client interviews recorded + (3 interviews not recorded due to malfunctioning equipment – field notes were made following these 3 interviews)
Research diary	→	A log of daily contacts with the case sites.

5.10 Inductive Data Analysis

This section will describe the aims of data analysis and critically discuss the strategies involved in the analysis of the multiple sources of data outlined above. One of the challenges presented by the data was its sheer complexity and volume. Initially it was important to review the aims and objectives of the research and to revisit these as data analysis progressed. The overall intention of data analysis was two-fold: to explicate the processes involved in health visitor professional judgement in identifying health needs and prioritising families requiring extra health visiting support. It was planned that information obtained through the analysis could be used as a framework for understanding judgement processes. Secondly to make explicit clients' perceptions of their health needs and how they perceive the health visitor's role in helping them to identify and address these needs. It intended to explore the links between practitioners' professional judgements and client perceptions about health needs.

Qualitative research produces extensive amounts of rich and complex data, which needs to be systematically and logically analysed (Miles and Huberman, 1989). Marshall and Rossman (1995:111) describe qualitative data analysis as:

> *the process of bringing order, structure, and meaning to the mass of collected data. It is a messy, ambiguous, time-consuming, creative, and fascinating process. It does not proceed in a linear fashion; it is not neat.*

Qualitative analysis is an inductive, highly interactive and iterative process, which requires the researcher as instrument to be extremely well organised and diligent. The interactive process incorporates two main elements, analysis, which involves organising data into manageable units and secondly, interpretation, "*bringing meaning*" to the units of data (Rossman and Rallis, 1998:171).

In constructivist inquiry, the purpose of analysis is to frame constructions which emerge through interactive data gathering strategies into "*meaningful wholes*" (Lincoln and Guba, 1985:333). Given limited empirical evidence about the nature of health visitors' judgements to increase support to families, the researcher anticipated that this approach to analysis would offer an understanding of the phenomenon of

professional judgement. She also intended to examine the observation and interview data for any evidence of health visitors' use of formal guidelines in identifying and assessing health needs.

Interestingly, Stake's (1995) description of how to go about analysing case study data is fairly intangible and offered little direction. This point was reinforced in his comment "*I seek to make sense of certain observations of the case by watching as closely as I can and by thinking about it as deeply as I can. It is greatly subjective*" (Stake, 1995:77). He states "*each researcher needs through experience and reflection, to find the forms of analysis that work for him or her*" (Stake, 1995:77). Unfortunately, this provided little help for the novice case study researcher grappling with the issues of case study design. Data analysis has thus been informed by a number of sources but focuses primarily on the work of Lincoln and Guba (1985) and Coffey and Atkinson (1996) and Mason (1996). In addition issues that had emerged during the preliminary work, that had informed data collection in the main study and had provided some insights about professional judgement, were also to inform the analysis, thus highlighting the sequential nature of the work. Data analysis was also guided by the researcher's own personal and intuitive knowledge of the field.

The constructivist method of data analysis can be summarised as a) unitising, b) categorising and c) searching for patterns (Lincoln and Guba, 1985). Data analysis is on going and takes place both during and following periods of data collection. The QSR.NUDIST software package was employed to assist in the processes of data organisation, management and analysis. The strengths of this software programme are well documented in the literature and highlight the ability to deal with a wealth of material and the speed with which text can be indexed, easily searched and retrieved. Creativity in data analysis is facilitated by exploring the relationships between concepts, reorganising these as necessary to create logical explanations and generate theory (Richards and Richards, 1991; Davis, 1997; Tak el al, 1999; Woods and Roberts, 2000). The programme helps to facilitate interaction between the coded data and the original data and provides a facility for auditing researcher thinking (each event) through dated and timed records.

Disadvantages of the programme centre around the problem for inexperienced users of the "*coding fetish*" (Richards, 1997; Pateman, 1998) which relates to the problem of generating too many codes early in the analysis. Creswell (1998) also suggests that codes may become fixed thus impeding data analysis and stagnating conceptual development. This problem is exacerbated by the software programme's huge storage space (Richards, 1997; Woods and Roberts, 2000). A further limitation includes the considerable time needed to become conversant with the QSR.NUDIST software, combined with the need for specialist training. There were also considerable personal limitations in not being able to visualise 'written' coding alongside text, being limited to margin 'coding stripes'. Finally, it is important to dispel the often wrongly held assumption that data analysis soft-ware packages will do the analysis, when in fact all they really do is assist with data management, including handling and retrieval of data.

Data organisation began with each recorded home visit and all the tape-recorded interviews being fully transcribed to typed format and then anonymised. Observation field notes were retyped and where possible incorporated/integrated with the audio-recording of the home visit. See Table 5.2 – Data Sources (Page.140).

For analysis purposes:

- The initial health visitor interviews have been kept separate. To compare health visitors' conceptualisation of professional judgement and perceptions of formal guidelines within and then between each case site.
- Data from audio-recordings of home visits have been combined with observation field notes.
- Data from field notes taken prior to the home visit, using the standardised framework during the informal interview with health visitors have been combined with the transcription of the post-visit health visitor interview.
- Client interviews have been analysed separately to compare within and across case study sites.

Data transcription of 172 audio-recordings into word files was a lengthy and exhaustive activity. Despite having some assistance with this stage, the researcher found it was essential to check all transcripts thoroughly against original tapes to ensure accuracy in transcription. A number of errors were found in material that the

researcher had not transcribed herself, for example "*a routine sort of removal in visit*" had been transcribed as "*a routine sort of run of the mill visit*" – thus completely changing the context of what had been said. Similar errors confirmed the need to and the importance of carefully listening to each tape while reading the associated transcript. This process was repeated several times in order to immerse herself in the data and become intimately familiar with it. Preliminary data analysis also involved making initial margin analysis notes about the content of transcripts.

Prior to importing documents into QSR.NUDIST they needed to be prepared for import to the software. At this stage important decisions had to be made about text unit length, and what could be considered as a meaningful unit of data. This stage relates to Guba and Lincoln's (1985) method of unitising data, where getting the data organised is crucially important. Text units of data can equate to a meaningful phrase, a single line of text, a sentence or paragraph:

> *it must be the smallest piece of information about something that can stand by itself, that is, it must be interpretable in the absence of any additional information other than a broad understanding of the context in which the inquiry is carried out* (Lincoln and Guba, 1985:345).

In this study, data was prepared so that text units were broken into sentences or two sentences if the same topic continued into a second sentence. Unitising the data involved dividing text into meaningful units and undertaking coding in a rigorous and systematic fashion.

It soon became evident that there were going to be multiple phases to the analysis, each illustrating different aspects of the data (Coffey and Atkinson, 1996). To make the data more manageable, initial analysis centred on the fifteen initial health visitor interviews. Sub-headers were used to section interview data to correspond to the responses to specific questions to familiarise ease of access to specific questions in the data set. All units of data were coded and given a numerical label called a 'node' and a name. Nodes reflected two types of information either descriptive or conceptual. Descriptive nodes can be added to a entire document to describe something about the study e.g. case site. Conceptual nodes related closely to the

content of participants' meanings and experiences.

Rather than adopting a pre-structured coding framework, an inductive and data-driven approach to analysis was selected and initially all nodes were coded as 'free' nodes. This stage of data analysis enabled the researcher to increase her familiarity with the data through a systematic process. No ordering of the data took place at this stage. It also meant that each text unit could be coded to several nodes. QSR.NUDIST's node defining and memoing facilities enabled notes to be made to track the analysis, as well as providing a record of the date and time for audit trail purposes. At this stage Lincoln and Guba (1985:346) recommend one "*to err on the side of overinclusion*" in order to maximise the chance of capturing all viewpoints. Indeed this strategy initially generated over 800 codes yet it also reflected the complexity of human thought processes with sections of data overlapping analytical categories.

Once initial unitising of these fifteen interviews was completed, initial categorisation followed. This involved grouping units of information (nodes) which appeared to have similar properties and content into a provisional category. Categorising data involves searching for patterns and recurring ideas within and across the data sets and was influenced by the preliminary study findings and earlier research work (Appleton, 1995). Analysis of these data centred on health visitors' descriptions and perceptions of their practice and provided contextual data, for example, about the existence of formal guidelines to identify families in need and Trust working practices. Initially data were grouped separately under the three sites, but this was soon abandoned, as it was possible to identify differences and similarities across the study sites by using a common grouping.

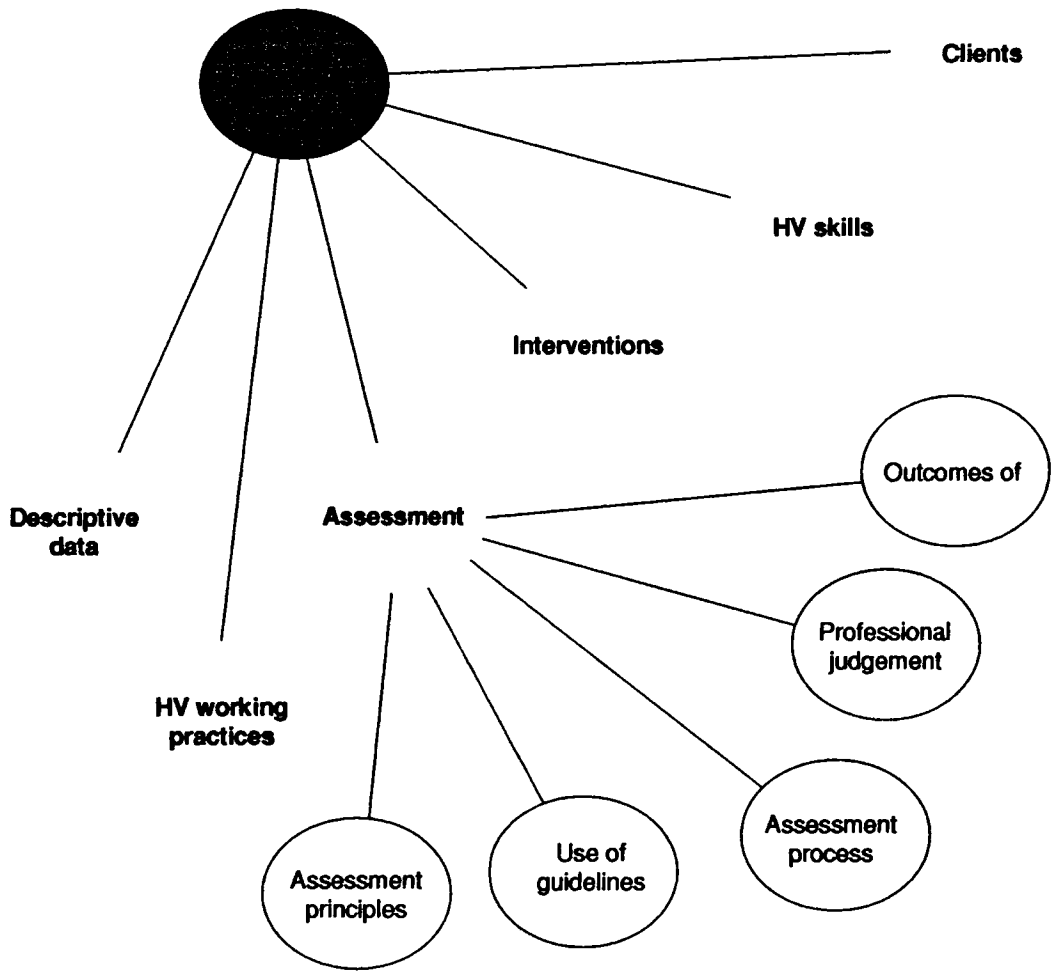
Data were initially sorted into categories of similar ideas. This enabled the development of a tree-structured index system with main categories and subcategories, known as 'child' or 'branch' nodes. This index system could be viewed as a list or as a visual display of a tree. Nodes containing units of text were reviewed, easily cut and pasted and moved around the tree structured index facility as the analysis progressed and as conceptual coding developed. Thus the preliminary

categories that emerged from the initial health visitor interviews were used to inform subsequent analysis and centred on:

- descriptive data
- HV working practices
- assessment
- interventions
- HV skills.

The process of unitising was then repeated with all subsequent health visitor, client interviews and audio-recordings of health visitor/client interactions. A further category was then added to the QSR.NUDIST tree – Clients (See Figure 5.4). Initially pre-home visit interview notes were treated as separate documents, however this was soon abandoned and they were combined with the relevant health visitor interview

Figure 5.4: Principle categories in the NUDIST Index System including major sub-categories of the assessment category



data. This facilitated ease of identification of patterns and differences between pre-visit interview notes and health visitor accounts of the visit.

Throughout these lengthy analytical processes initial coding was constantly compared and refined so that where links and relationships were identified nodes were either merged together or hierarchies developed with a main category and series of subcategories (child nodes). The features and properties of categories were continually examined. Tentative working hypotheses and links/connections between categories were explored, for example, health visitors' perceptions about formal guidelines were examined in light of the case sites existing policy guideline. Codes and categories were continually reviewed, questioned and revised as analytical processes progressed and disconfirming evidence was sought.

Despite this initial stage of thematic analysis providing a rich and insightful data base, the researcher began to feel stifled by the use of the QSR.NUDIST software. The analysis undertaken using QSR.NUDIST indicated that the processes involved in health visitor assessment were important in informing professional judgement. Indeed health visitors had alluded to the processes they utilised when making their professional assessments. But because the four data sets seemed very separate, there seemed to be an inability to pull the whole picture together. Limitations centred on the fact that for the health visitor and client interviews, participants may not have accurately reported their activities, while data from observation field notes and the audio-recordings of client/health visitor interactions provided an opportunity to check out these views. But it was difficult to visually combine these data sources and uncover the interlinking issues despite the fact that these methods of data collection had intended to be complementary.

The researcher also found it extremely debilitating in not being able to visualise all coding against data on the computer screen. A further drawback as Bryans (1998) found was the fact that only a small section of text can be displayed on the screen so this has limitations when examining the detailed processes involved in the client health visitor interaction. Data from health visitor client interactions was de-

contextualised, the processes involved in the client health visitor encounter were often too lengthy or complex to be captured on the computer screen. For example, during a home visit, a client may express a need but this may not be picked up by the health visitor until a bit later on in the conversation. Thus it was difficult to make much sense of these complex processes by on-screen analysis, because the data seemed very fragmented through the process of unitisation.

In an attempt to address the above limitations of QSR.NUDIST the researcher reverted to a manual approach to analysis in order to further facilitate her engagement with the data and its context. Indeed this seemed extremely applicable for this constructivist inquiry where the focus of interest centred on the process of health visitor professional assessment and judgement formation through an examination of health visitors' interactions with their clients. The researcher revisited each transcript from each data suite. For every visit, a data suite consisted of:

- a transcription of the audio-recordings of home visits and observation field notes
- field notes taken prior to the home visit combined with the post-visit health visitor interview
- post-visit client interviews.

Each document was re-read and marginal notes were used to further develop ideas and examine new interpretations and leads in the data (Miles and Hubermann, 1994). This process enabled the researcher to think more deeply about her data and to begin to look for patterns within a transcript. Having undertaken this preliminary stage, to facilitate an understanding of issues occurring across the suite, contact summary forms were produced for each of the 56 data suites. Using these contact summary forms as a framework, key categories and sub-categories which had emerged from the initial QSR.NUDIST analysis were explored further initially within each data suite and then across the suites of each health visitor. So for example, if a health visitor was observed to question a client about other family members, did she recognise this as part of her assessment strategy and did the client make any comment about this. Was this a strategy that she adopted across the four visits or not? At the end of each contact summary form a short précis of each visit was written.

Transcripts were closely scrutinised for the existence of any evidence about the use of formal guidelines in practice. Process elements were tracked within suites, comparisons were reviewed and many questions asked of the data. For example, did the health visitor's agenda alter following the pre-visit interview? If so, how did the agenda alter? Did the health visitor, when interviewed describe responding to client cues during the visit? From the observer's perspective, did the health visitor apparently respond to client needs or not? Were health visitor judgements shared with clients or perhaps modified in response to client cues? Did the client perceive that the health visitor had responded appropriately to their expressed needs? Resulting ideas were then mapped using excel charts and diagrams. These summary tables enabled the recognition of patterns and inter-relationships, as well as generating further questions and the opportunity to interweave new ideas into the analysis and examine emerging themes.

5.11 Issues of rigour

Qualitative research is often criticised for failing to adequately address issues of rigour (Le Compte and Goetz, 1982; Appleton, 1995). Establishing the trustworthiness of a study is of fundamental importance to a constructivist inquiry and this issue must be explicitly and openly addressed throughout the research. Lincoln and Guba (1985:290) argue that all research must be concerned with addressing these four questions:

- ***Truth value:*** *How can one establish confidence in the 'truth' of the findings of a particular inquiry for the respondents with which and the context in which the inquiry was carried out?*
- ***Applicability:*** *How can one determine the extent to which the findings of a particular inquiry have applicability in other contexts or with other respondents?*
- ***Consistency:*** *How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) respondents in the same (or similar) context?*
- ***Neutrality:*** *How can one establish the degree to which the findings of an inquiry are determined by the respondents and conditions of the inquiry and not by the biases, motivations, interest, or perspectives of the inquirer?*

Unlike positivist researchers who would address these questions by examining internal and external validity, reliability and objectivity, constructivists apply rigour to their research studies by adopting an alternative set of criteria. Lincoln and Guba (1985:300) recommend that researchers should concern themselves with issues of "*credibility*", "*transferability*", "*dependability*" and "*confirmability*". This section will explore how these terms were used as a framework for addressing rigour in this inquiry.

5.11.1 Truth value

Guba and Lincoln (1981) suggest that the 'truth value' of a qualitative study should be evaluated by its credibility rather than internal validity as in scientific research methods. Credibility is achieved by demonstrating that the researcher has accurately represented the multiple constructions of participants in the study findings and interpretations (Lincoln and Guba, 1985). These authors propose a number of techniques to establish the credibility of a constructivist inquiry including prolonged engagement, persistent observation, triangulation, member checking and the maintenance of a reflexive dairy.

Prolonged engagement involves spending enough time in the study sites to learn about the culture, to build up trusting relationships with study participants and to reduce the possibility of distortions arising from either the self or respondents (Lincoln and Guba, 1985). In this study the researcher spent a considerable amount of time in each site engaging managers' and health visitors' interest in the study. Main study data collection took place over a period of twelve months, with the researcher working closely with each health visitor, conducting visits and interviews over seven months in Site A, eleven months in Site B and eight months in Site C. By accompanying each on four home visits, this enabled the researcher to get to know the health visitors, build up a rapport with them and develop trust. Considerable time was spent travelling to and from visits with participants and talking with them on the telephone. This helped to build up a close working relationship with the health visitors and was extremely important in reinforcing her role as an interested outsider, not part of the establishment. It was also crucial in increasing the likelihood of gaining access to vulnerable client groups. Prolonged engagement also provided the

researcher with sufficient opportunity to examine and check information emerging through early analysis of interview data and field notes.

Persistent observation is concerned with depth of data and is extremely important in ensuring that early working hypotheses are continually tested and challenged. Its purpose is to "*identify those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focussing on them in detail*" (Lincoln and Guba, 1985:304). This is important to differentiate between key issues and atypical, apparently less relevant happenings. During the early analysis, data categorisation, which took place following the fifteen initial health visitor interviews, identified a number of potentially important issues around health visitor assessment. These salient points were continually examined and challenged as data collection and analysis progressed and emergent patterns confirmed.

Triangulation involves using data from a number of different sources to strengthen evidence by completing pieces of the jigsaw and enriching meaning by further illuminating participants' constructions. During data analysis the researcher repeatedly referred back to the different data sources when developing categories and themes. This is an essential step, actively searching and checking the data for reasons why conclusions should not be trusted. The researcher was continually aware of the threat to credibility from the 'holistic fallacy' (Miles and Huberman, 1994) which can occur as the researcher becomes more certain that his/her conclusions are correct. The researcher paid particular attention to any exceptions to findings. Also, by using data from a number of different sources, the risk of the 'holistic fallacy' was diminished (Miles and Huberman, 1984).

Lincoln and Guba (1985) advocate the use of both formal and informal member checking to increase credibility in a study. Member checking is:

> *the process of testing hypotheses, data, preliminary categories, and interpretations with members of the stakeholding groups from which the original constructions were collected* (Guba and Lincoln, 1989:238-239).

Informal member checking occurred in this study when during an interview or at the end of an interview or observation period the researcher sought to check out her understanding of what had been said or done by respondents in order to clarify meaning and interpretation. This was important in order to address any ambiguity and clarify confusion on the researcher's part.

To further enhance credibility, formal member checking is also recommended by Lincoln and Guba (1985) and involves returning copies of transcripts or research findings to respondents and asking them to check that results are representative of their experiences. However, this does raise questions about when member checking should occur and what aspects of the data are presented to respondents (Sandelowski, 1993). Sandelowski (1993) and others (Long and Johnson, 2000) believe that such procedures for achieving trustworthiness are open to criticism. Sandelowski (1993) argues that participants will inevitably seek out their own constructions of reality, rather than a consensus viewpoint. Also there may be problems associated with memory lapse and denial. Sandelowski (1993) describes participants' stories as being time bound and that people can move on in their thinking and views. Furthermore, it may be difficult to access some respondents again, particularly in the case of vulnerable groups such as some of the people participating in this study. There may also be ethical concerns if revisiting data causes participants distress.

To address such concerns Sandelowski (1986) has suggested presenting findings to other similar groups, to determine the degree to which the findings have meaning for people working in other similar contexts. The aim of this activity is to check the credibility of findings, to see if they reflect other people's experiences and perceptions. The descriptive interpretation which results from the analysis should apply to health visitors working in other areas as the aim of the study was to produce a rich data base in order to gain understanding of professional judgement. Since completing the study the researcher has had the opportunity to discuss the findings with health visitors working in a number of different areas of the United Kingdom, and certainly the interpretation of the analysis does appear to be mirrored in other areas. She has also presented her interpretation of the study findings to some of the

research participants. All the above activities have helped to establish credibility in verifying that the emerging themes were meaningful and accurately reflected people's experiences (Appleton and King, 1997). A constructivist inquiry is thus deemed credible if it reveals accurate descriptions of individuals' experiences and "*that the people having that experience would immediately recognise it from those descriptions or interpretations as their own*" (Sandelowski, 1986:30).

5.11.2 Applicability

Applicability in qualitative terms is regarded as parallel to the notion of external validity in quantitative research (Guba and Lincoln, 1989). External validity refers to "*the generalisability of findings and the representativeness of subjects, tests and testing situations*" (Sandelowski, 1986:31). Yet such a measure is inappropriate in constructivist inquiry, where as discussed in Chapter 4, seeking generalisations is not intended. Instead it is the uniqueness of settings which is particularly valued and "*context-specific interrelationships*" (Erlandson et al, 1993:16).

Lincoln and Guba (1985) suggest that the idea of 'transferability' previously described as 'fittingness' (Guba and Lincoln, 1981) is more appropriate and should be used to establish applicability in a constructivist study. Thus the concept of generalisability is altered to that of transferability in which the responsibility lies with individuals who seek to apply the findings to other contextual settings (Lincoln and Guba, 1985; Appleton and King, 1997). Through the 'thick description' emerging from this study, it is hoped that readers may find similarities between settings which gives them confidence to apply the results to their own practice (Sandelowski, 1986, 1993; Lincoln and Guba, 1989). A study whose findings 'fit' contexts outside the current research study situations can be described as having transferability. This is further supported when readers/practitioners view the study findings "*as meaningful and applicable in terms of their own experiences*" (Sandelowski, 1986:32).

As discussed earlier in this chapter, purposive sampling is crucial in uncovering a range of information and extremely important in generating rich descriptions about the case. This sampling strategy was a central feature of the main study and was essential in

uncovering the range of views and illuminating the phenomenon of professional judgement. While it as impossible to reduce the threat totally of 'elite bias', that is "*overweighting data from articulate, well-informed, usually high status informants*" (Miles and Huberman, 1994:263), the researcher selected participants on the basis of their interest in the study and likelihood of them helping her to access vulnerable clients.

5.11.3 Consistency

Guba and Lincoln (1981) suggest that the 'consistency' of a constructivist inquiry should be evaluated by its dependability. Dependability is regarded as a parallel measure to that of reliability, "*in that it is concerned with the stability of the data over time*" (Guba and Lincoln, 1989:242). However, Sandelowski (1993:3) argues that repeatability is not a critical feature of qualitative research where "*reality is assumed to be multiple and constructed rather than single and intangible.*" In constructivist research reliability seems something of a red herring, as "*methodological changes and shifts in constructions are expected products of an emergent design*" (Guba and Lincoln, 1989:242). In contrast to scientific research that aims for repeatability of measures and consistent responses, constructivist research "*emphasises the importance of experiences that are not necessarily accessible to validation through the senses.*" (Sandelowski, 1986). Lincoln and Guba (1985) therefore propose that the 'concept of auditability' be the measure of consistency or dependability in a constructivist inquiry.

However, one could argue as Long and Johnson (2000:31) have that essentially the basic concern of dependability is the same as for reliability: "*to ensure that data collection is undertaken in a consistent manner free from undue variation which knowingly exerts an effect on the nature of the data.*" Lincoln and Guba (1985) suggest that dependability is established through the maintenance of a clear audit trail. They suggest that a study may be judged as auditable if the reader can follow the "*decision trail*" of the research process and product (Guba and Lincoln, 1981:122; Koch, 1994). Thus this thesis has been written with a view to giving the reader sufficient detail and information to track the progress of the study and capture the 'decision trail'.

Interviews were used in this study to discover client and health visitor constructions. The quality of data elicited is dependent upon the competence and ability of the researcher's interviewing skills and on any researcher bias (Guba and Lincoln, 1981). Reflecting on this it is likely that as the study progressed, the researcher's interview technique improved which may well have influenced the quality of data produced. In later interviews with the health visitors it become apparent that the researcher became more probing, which is likely to have resulted from a combination of her increasing confidence, her insights and understanding gained from early analytical processes and the fact that the health visitors became more at ease as trust developed. Semi-structured interview schedules were used in order to increase the consistency of data collected (Brink, 1989), however this did not preclude interview content deviating from these schedules. All interviews and home visits were audio-recorded to increase consistency.

5.11.4 Neutrality

Finally, neutrality which "*refers to the freedom from bias in the research process*" (Sandelowski, 1986:33) was addressed in the study. Lincoln and Guba (1985) argue that the focus should be shifted from the objectivity of the observer to whether or not the characteristics of the data are confirmable. These authors have proposed that in a constructivist inquiry, confirmability that is achieved by establishing auditability, applicability and truth value should be the standard by which neutrality is judged (Guba and Lincoln, 1981). In other words the researcher clearly justifies what was done and why at each stage of the research process, to demonstrate how interpretations have emerged.

Auditability has been attempted in this study by the researcher clearly describing each stage of the research process, explaining and justifying what was done. Data extracts are linked to source, so that conclusion and interpretations are open to (external) scrutiny by the reader. It is possible that interviewer bias may have also been present in the fact that the researcher herself is a health visitor. However, the researcher tried to overcome this by maintaining a neutral stance, being as non-judgmental as possible during data collection and by not presenting her own perceptions to respondents. A research diary was maintained by the researcher which provided an opportunity to

critically reflect on the steps involved in the research process and to examine her own personal beliefs and behaviour. This further enhanced the trustworthiness of this research by offering another route for establishing auditability of decision processes.

5.12 Summary

This chapter has demonstrated how a case study strategy guided by a constructivist methodology was utilised as a framework for the main research study. A framework for constructivist investigation developed from the original work of Lincoln and Guba (1985) has been used to detail the steps of the research methodology and explicate the researcher's decision making in examining the concept of professional judgement. The following five chapters will describe the key findings of the main study.

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Chapter 6

The Guideline Contradiction

6.1 Introduction

During the preliminary study it became evident that a range of guidelines exist throughout the country to assist health visitors in the identification and assessment of children and their families deemed to require additional support. Indeed Chapter 3 raised a number of questions about the extent to which health visitor professional judgement is influenced by the presence of such formal guidelines. Therefore a deliberate intention of the study design was to select three Community Trust sites where contrasting guidelines were issued to health visitors to assist in the identification of vulnerable families. This strategy was adopted to examine health visitor professional judgement and to explore the potential impact of differing guidelines on health visitor practice. By gathering a variety of constructions it was intended to investigate the extent to which formal guidelines influence health visitors' professional judgements in determining to increase support to families. The aim in selecting three different cases was to maximise the possibility of capturing multiple perspectives in the study contexts, which could help to illuminate the phenomenon of health visitor professional judgement.

This chapter will initially describe the individual characteristics of the formal guidelines existing in the three case study sites to assist health visitors in identifying families requiring extra support. Health visitors' perceptions about the adequacy of such guidelines for identifying families in need will be explored. In addition it will highlight the apparent impact of core visiting protocols in providing a baseline for client contacts, with any contact above this being perceived as an indicator of extra

health visiting. The presence of such protocols hints at elements of control by managers, leading to conflicts in the relationship between professional judgements and official guidelines. Finally the chapter will illustrate how a gap in knowledge has been explored through an examination of the use of formal guidelines in practice.

6.2 A description of the guidelines in each case study site

Table 6.1 'Case Site Guideline Summary' provides an illustrative overview of the formal guidelines existing in each study site. An interesting feature of the analysis was the variety and range of criteria available for the identification of families needing increased support. The following sections will describe in more detail the characteristics of the guidelines existing in each study context.

6.2.1 Study Site A

Trust Site 'A' has no formal guideline to assist health visitors in identifying families needing extra support. The Trust was exploring the concept of 'packages of care' and considering the introduction of a vulnerability score at the initial needs assessment contact. Managers wanted to introduce a score encompassing factors amenable to health visiting intervention, rather than one focussing purely on traditional social indicators. Trust management wanted their purchasers to understand more fully the range of therapeutic interventions undertaken by the health visitors. They also wanted to achieve some consistency of approach among health visitors in their response to families with certain needs, to begin to demonstrate effectiveness. The Health Visitor Manager explained that the families identified by different health visitors as a 'cause for concern' varied as much with the experience of the health visitor and his/her individual framework for visiting as with the more 'objective' health needs (amenable to health visiting intervention) in the caseload.

As part of an internal audit, all health visitors in the Trust had recently been asked to record over one month, the reasons why they made 'high intervention' contacts to families. ('High intervention' was the term commonly used in this site to refer to families receiving extra health visiting). The information collected revealed a wide range of reasons why families were offered increased intervention. The audit also

Table 6.1 Case study sites – guideline summary

HV	Formal Guidelines				Other Practice Guidelines and HV awareness of			
		Type of Formal Guideline	HV aware of Formal Guideline	HV use of Formal Guideline	Core Programme	Local Assessment Framework	HV aware of Local Local Assessment Framework	HV use of Local Assessment Framework
1.15	No	N/A	N/A	N/A	Yes	Health Profile	Yes	Yes
1.25	No	N/A	N/A	N/A	Yes	Health Profile	Yes	Yes
1.39	No	N/A	N/A	N/A	Yes	Health Profile	Yes	Yes
1.7	No	N/A	N/A	N/A	Yes	Health Profile	Vaguely mentions by name	Not apparent
1.82	No	N/A	N/A	N/A	Yes	Health Profile	Yes	With difficulty
2.06	Yes	Priority Index Guideline	Yes	Yes as a prompt.	Yes	N/A	N/A	N/A
2.2	Yes	Priority Index Guideline	Yes	Yes.	Yes	N/A	N/A	N/A
2.38	Yes	Priority Index Guideline	Yes	Yes for classifying . needs. As an aide memoire	Yes	N/A	N/A	N/A
2.77	Yes	Priority Index Guideline	Yes	Yes to structure work.	Yes	HV records	HV records	HV records
2.91	Yes	Priority Index Guideline	Yes	Yes - "loosely"	Yes	N/A	N/A	N/A
3.07	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No	Yes	HV records/proforma NCAST, CDP and IUM	HV records/proforma NCAST only used in some localities Refused to use CDP and IUM	HV records/proforma
3.49	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	Uses CDP.	Adheres to CDP	Child Development Programme (CDP) and IUM	Child Development Programme (CDP) and IUM	Child Development Programme (CDP) only at present
3.53	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No	Yes	A family profile and scoring system	A family profile and scoring system	No
3.71	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No.	Yes - limited	NCAST and Local Assessment Framework	NCAST and Local Assessment Framework	NCAST and Local Assessment Framework
3.89	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No	Yes	N/A	Child Development Programme (CDP)	No

Key: CDP = Child Development Programme IUM = Integrated Urban Model NCAST = Nursing Child Assessment Satellite Training Tool

indicated that practitioners worked in very different ways, with some health visitors undertaking very little 'high intervention' work apart from additional checks on children's development (as a safety net). Others appeared to have quite a common theme to the families they 'selected' – i.e. mostly with behaviour problems or infant growth problems, while others had a wide range of issues represented in their 'selection' of families.

A 'Strategy for Health Visiting' had recently been implemented in the Trust and a framework outlining the service which acknowledged different aspects of health visitors' work. This included:

- Family Health Needs Assessment (Health Profile)
- A Core Programme of proactive contacts when a child is at specific ages
- High Intervention Work (reactive intervention – problem centred)
- Public Health
- Group Based Health Promotion Work.

The Health Profile

The Health Profile is a form, consisting of two sheets of A4 paper with a list of headings for a health visitor to document an assessment of a family's health status, to record advice given and any action taken. The assessment document takes the form of a trigger list of potential family health needs to discuss with the parent/carer. The profile focuses on lifestyle factors (smoking, diet, exercise, alcohol and drugs), coronary heart disease (including heart attack, stroke, hypertension, diabetes), cancer (cervical, breast, testicular, skin and others), sexual health (family planning, contraception, safe sex), mental health (including depression, bereavement, anxiety/stress), childhood (developmental problems, major illnesses/accidents) and other significant health needs.

Health visitor perceptions of the Health Profile

The Health Profile was described by four of the health visitors in Site A as a tool to direct family health needs assessment, yet interestingly only vaguely alluded to by HV 1.70. A number of health visitors described how the profile was linked to

Government public health targets and many regarded it as an aide memoire or checklist for assessing family health. It is supposed to be completed at the new birth visit or at a transfer in visit and updated at the 2-year development check. However, health visitors described using the assessment tool flexibly. It is explained by HV 1.15 as follows:

> *It's a form ... I mean it obviously is a bit of an aide memoire for us but it – we do actually write it down in a fairly structured way and tell the parents that this is something we just keep in the back of the child's notes ...*
> (HV 1.15:197-199)

There was a view that the Health Profile enables health visiting to take a broader focus, in that it offers practitioners an opportunity to discuss health issues that may not be routinely addressed, particularly at an early stage in a health visitor/client relationship. Indeed it can provide the health visitor with a trigger or cue to pick up on, or to enable clients to discuss wider family health needs especially those relating to family medical history and other family members. Health visitors also describe the tool as helpful in raising clients' awareness about potential health needs.

Despite the potentially intrusive nature of questions surrounding drug or alcohol use, difficulties in raising these issues may be overcome by a health visitor who is a skilled and tactful communicator. One health visitor commented:

> *I think it's very useful ... and certainly the families don't seem to resent you going through all these areas with them it's – it never seems to be a problem and certainly for a lot of them it – it's – it does enable you to give them a lot of advice that you know you might not otherwise get round to ...*
> (HV 1.15:209)

The Health Profile may also offer clients an opportunity to raise sensitive issues. This appeared to be particularly the case when health visitors described situations where clients had disclosed a bereavement, mental health issue or other personal health need to them. Health visitors also found the tool helpful in facilitating them to raise sensitive issues with clients for example issues around sexual health, which otherwise might be difficult to address.

During one observed visit HV 1.39 gave a really good example of how undertaking the Health Profile enabled her to open up several health needs with a first time mother:

> *... and I mean the first question I asked was whether do you or [partner] smoke. I mean she could have said "no"* [chuckles] *just a plain "no" but she actually said "no I gave up three years ago" and I don't know why I really don't know why I asked "what made you give up?" But it was asking that question that then opened the can of worms and got all the information about her panic attacks and how ill she'd been ...* (HV 1.39.2:105)

This health visitor describes the subsequent information that this client shared with her as "*an absolute minefield ...*" (HV 1.39.2:111) and how significant it was in her assessment of this family's needs.

Others were more critical of the Profile, one practitioner found it awkward to introduce and use in her practice, describing it as "*quite clumsy to work with*" (HV 1.82:443) and containing too much information to memorise. She argues that it does not fit in with her approach to health visiting and is critical of the guideline for not necessarily addressing a family's immediate needs or the client agenda.

Despite the potential auditability of the Health Profile, there was a shared sense of feeling amongst practitioners that nothing is done with the information collated, it is filed away in the child's record and only reviewed by the health visitor when a child is 2 years old. Indeed health visitor 1.39 explains how she thought the intention when the Health Profile was first introduced was to collate the data in view of the Health of the Nation targets (Dept. of Health, 1992), but that this initiative was never established.

6.2.2 Study Site B

Priority Index Guideline

In Site B the guideline that exists for health visitors to identify families in need takes the form of a vulnerability screening tool of risk indices. The Priority Index Guideline (PIG) was adapted for use from an index system developed and used in another Community Trust becoming operational in Site B in October, 1993. An A5 index card is prepared for all children under 5 years and any individuals receiving extra health

visiting on the caseload. Subsequent contact is planned according to assessed need, then prioritised, categorised and recorded in the index card and health visitor record. Index cards are then filed in a box, with Trust guidelines stating that boxes should be updated monthly to organise the work and reviewed weekly to assess progress.

In this guideline clients needs are assessed, prioritised and categorised according to high, medium and low priorities. The guideline consists of 6 high priority categories (families requiring short term intensive health visiting input), 16 medium priority categories (reflecting clients whose needs are being reviewed regularly) and low priority, which is the remainder of the caseload, offered the basic health visiting service of routine child health surveillance programme contacts. Written guidance accompanying the Priority Index Guideline describes the need "*to maintain standardisation*" across priorities and within categories through regular review with colleagues and managers. The guidance appears to acknowledge a degree of professional judgement in stating:

> *It is not intended that all clients of a certain description are fitted into a particular category but should be categorised according to their individual need for the service. Clients have differing qualities and access to facilities that may indicate different levels of Health Visiting is required therefore they would be categorised accordingly. Where clients need scans several categories the major categories should be recorded on the index card.*
> (Trust Guidance, 1993)

Health visitor perceptions of the Priority Index Guideline

All five health visitors involved in Site B, talked about the Priority Index Guideline with HV 2.38 and HV 2.91 explaining its origins. Most described it as tool to plan, organise and prioritise their work. It was interesting to find that health visitors' views varied about the extent of their use of the guideline in practice. One health visitor who felt that the Priority Index Guideline may be useful for newly qualified staff, proceeded to say that she does not use the tool as much as perhaps health visitors working with a corporate caseload because "*I meet everybody and I can assess everybody*" (HV 2.20:347). However this health visitor did comment that she keeps the PIG categories at the back of her mind: "*You don't consciously think about them.*

But if any of those issues are there, then you're more concerned about a family." (HV 2.20:437). Another health visitor described using the PIG only "*loosely*" (169) .... "*Why do I say loosely? Because – I mean it's either low, medium or high as far as I'm concerned. I don't tend to say M6 or ....*" (HV 2.91:171). Indeed she says that she would not be considering the risk indices when making an assessment of a family's health needs.

There also appeared to be some discrepancy in the use of the system with some health visitors stating that they were recording specific categories on the health visitor records before placing a card in the appropriate section of the PIG box, while others recorded the level of intervention only without specifying clearly the extent of a family's need. Other health visitors just placed a card highlighting the category of need in the index guideline. It was interesting to note that only one health visitor, HV 2.91 acknowledged that it might be difficult to move a family from a medium/high intervention category back to the low category once a period of increased support was completed.

One of the key advantages of the Priority Index Guideline is its use in highlighting planned contact with clients. It can be helpful as an aide memoire to identify such contacts and appears to be a way of logging an assessment, then prioritising and planning the workload.

> *I think it's extremely useful. It also is an aide memoire for doing developmentals and if you sort of think somebody's got a speech problem and you'll ring them in two months time, it actually comes up on the card and you think, oh yes, I've got to ring them ... You don't have to write numerous pieces of paper, just get a card and do it. And it works very well with us. And if we drop dead or whatever, somebody could walk straight into our case load and pick it up.* (HV 2.77:316-317)

There was a consensus of opinion that it can be useful in highlighting need on a caseload if the health visitor who manages that caseload is away, as every health visitor in Site B is supposed to be using the system and bank staff are also familiar with it. Indeed some health visitors felt that this was its main purpose.

In reality however the system is unlikely to be foolproof for identifying families needing extra support. Problems were highlighted in two areas: firstly HV 2.77 described having logged a family under medium but actually visited as if they were a high priority, because of her gut reactions. Therefore the level of recorded prioritisation did not reflect this health visitor's actual working practice. Furthermore, having adapted the PIG, anybody covering the caseload would not recognise that high priority work had been conducted. Secondly HV 2.38 described how in the case of a vacant caseload where the index box was not kept up to date by the team, it soon became redundant as a work planning tool.

Views were mixed about whether the Priority Index Guideline can help a practitioner to highlight and categorise health needs. HV 2.91 found it particularly helpful in determining and sorting out low and medium priority work, but states that high priority work is usually at the forefront of a professional's mind anyway. Another health visitor suggested that the named categories within the Index guideline could raise awareness about a family's specific health needs. She suggested that the guideline encouraged her to reflect on the cause of any 'feelings' prior to categorisation. Because the guideline requires health visitors to categorise family needs she felt it made her unpack what was causing her to experience a 'feeling' before categorising a need within the Index.

Gut feelings are not acknowledged in the Priority Index Guideline yet some of the health visitors felt that gut feelings can be manipulated to fit the PIG if they are linked to an obvious health need. Identifying the health needs around any 'feelings' experienced appeared to be a way of acknowledging and legitimising intuition. However HV 2.38 describes how difficult it can be when she experiences a gut feeling and this is not reflected within the guideline. She describes trying to slot the 'gut feeling' into a particular category in order to try and reflect her professional concerns but admits that "*It's not really that easy to do ...*" (HV 2.38:456).

Some of the health visitors also described how even some common health needs and problems don't fit into the categories within the guideline. This results in needs and

problems having to be made to fit categories that are not necessarily appropriate. A frequently cited example was postnatal depression being categorised under 'mental health issues'. One health visitor explained her discomfort with this:

> *I don't like the terminology of it I think if it was postnatal depression written down there I'd be quite happy, but I think there is so much stigma attached to postnatal depression to log it under mental health issues to me just doesn't, it just doesn't quite feel right...* (HV 2.06:241)

Difficulties can occur with the PIG criteria when a health visitor makes an assessment that a family needs extra support for a reason that does not closely fit the criteria. This tends to be either because the need is not listed or the needs highlighted are not specific enough and are not a true reflection of health visitor workloads. This may result in a health visitor intervention being logged in the Index in the medium category when high priority work is being conducted.

A major problem with the guideline and one described by all the practitioners was the fact that in reality it does not actually help in the assessment of families needing extra support. Instead health visitors make an assessment prior to categorising need within the prioritisation guideline framework. Health visitors frequently described making their own judgements about whether families needed extra support without referring to the guideline at all. They then described slotting client needs into appropriate categories:

> *Well I don't think it helps you assess because there's no, I mean basically it's your judgement that puts them under the certain criteria.* (HV 2.06:230)

Another difficulty associated with the Priority Index Guideline is the additional work it creates. Although HV 2.06 describes it as a system for logging an assessment and for prioritising subsequent client contacts, she appeared to be duplicating work by also recording planned contacts each month in her diary. Other health visitors also commented on the extra work attached to using the guideline, while some described having their own systems for organising workloads, for example HV 2.38 planned work from her birth book and HV 2.20 described having "*a little red box*" (HV 2.20:351) as an aide memoire for client contacts.

6.2.3 Study Site C

Map of risk factors

During the preliminary guideline study two lists of risk indices were received from Site C, an older risk assessment tool and a recently introduced guideline. The old guideline consisted of a list of risk factors focussing on the parents, child and socio-environmental factors. The recent version is a map of predisposing risk factors contributing to an explanation of child abuse. The indices within the map focus solely on the parents and social environment. However accompanying guidance acknowledges the ability to exercise professional judgement as a caseload manager is an important health visiting skill.

A significant feature and one that became very apparent as the study progressed was the fact that none of the five health visitors in Site C were aware of either formal guideline. This appears to indicate that guidelines had been developed at a managerial level yet information about such policies had not been disseminated effectively to field staff. It also highlights one of the inherent problems discussed in Chapter 3 with regard to the analysis of secondary data. It accentuates the fact that in analysing the guidelines as a secondary data source no accurate assumptions can be made about health visitors' actual knowledge of or use of such guidelines in practice.

Indeed this site was split into several localities, with staff working in each of these areas adopting very different assessment strategies. A striking feature was the variety of practice evident, which may reflect the fact that the Trust covered a very large area, including an inner city area, as well as industrial and rural towns. However a number of health visitors did have insights into the assessment guidelines being used in other localities in the Trust. This seemed to be particularly the case with more recently qualified staff. There were also indications that health visitors did have a choice in the adoption of formal guidelines, which in some cases appeared to reflect a level of practitioner empowerment by Trust management.

For example, one health visitor described how she and some of her colleagues chose to adopt the Child Development Programme (CDP). She explained why it is only used in some parts of Site C:

> *some health visitors didn't want to work that way, and others did. And unless a centre, all health visitors agreed, it just didn't happen, but the management wouldn't impose it on us.* (HV 3.49:612-615)

Only one participant was involved with the Child Development Programme and this practitioner had been working as a first parent visitor for several years – regarding it as "*the best tool* [she'd] *ever been allowed to use*" (HV 3.49:20). She was soon going to adopt the Integrated Urban Model, where she will do all the first parent visiting and then keep the families on, on her own caseload. She describes how the CDP offers each first time parent approximately seven visits in a baby's first year and twelve if extra support is needed. The programme incorporates the use of structured questionnaires, assessment forms and a range of printed cartoon materials.

When questioned about how professional judgement is influenced by the use of a fairly structured programme, she responded by stating that "*partly the decisions are made*" (HV 3.49:303), to the extent that the programme appears to indicate who will get extra support. This sometimes includes clients where needs are not apparent, yet this health visitor argues that if a client makes use of the service this might enable a practitioner through partnership working to uncover hidden needs more effectively. Arguably if very narrow criteria are used for who gets visits, clients whose needs and vulnerabilities are not initially obvious may be missed.

This health visitor is very enthusiastic about the CDP regarding it as an empowering tool and clearly values the structured framework adopted at each client contact:

> *I know it's got its faults, but I like it because it focuses me ... It encourages what I believe in, which is to praise and acknowledge what they're doing right. ... I think that the first time parent is a kind of a window of opportunity. I've been reading some research from Sweden lately, where they have proved very conclusively that the pattern set in the first year of parents' life, is quite often carried through with other children. So it's kind of an optimal time for health visiting input. (HV 3.49:22- 34)*

She describes how through regular visiting she is able to facilitate discussion about children's needs, raise client awareness and empower clients to use their own initiative. HV (3.49) also appreciates the support meetings that she attends with other colleagues using the CDP, regarding it as, "... *a culture of support*" (HV 3.49:506) and finds it particularly helpful to gather ideas about how to progress with certain clients. She also values the accompanied visits undertaken as part of the programme training and the feedback she has received on her practice.

Despite this health visitor's enthusiasm for the CDP, other health visitors clearly have negative feelings towards the programme, which she recognises. Indeed another health visitor, although aware of the CDP and IUM, refused to adopt this way of working despite management pressure. She is critical of the fact that the model was introduced without a thorough audit being conducted first and regards the name 'The Integrated Urban Model' as inapplicable to her practice area, a rural market town. She describes the IUM as:

> ... *unworkable because of my caseload ... and apparently it was to supposedly to show outcomes, however it didn't actually state or there was no room to show that anything that I had said, done or written made any influence on the change ... It could have been anyone or anything. It didn't reflect on me. And I felt it was quite worrying because I thought well, if managers see that this is what health visitors do, then* – [scoffs] *well any old fool can do that, so I felt it was very worrying* ... (HV 3.07:349-352)

In practice HV 3.07 said that although she has no guidelines to assist in identifying families needing extra support, she does use her health visitor records as a proforma for initial antenatal and new birth assessments.

Another health visitor (HV 3.71) working in a Nursing Development Unit in a different locality described piloting the use of two different assessment guidelines. Firstly, a local assessment framework intended to be used by all the community nursing team in order to prioritise need and overcome an emphasis on crisis work(ing). Secondly, she described the NCAST (Nursing Child Assessment Satellite Training) tool, which consists of a series of scales to score parent-child interaction

during either feeding or play. It is an American model developed in Seattle and is being piloted in the locality for a year. HV 3.71 explains:

> *it really focuses on observing children's cues, disengagement and engagement cues, an awful lot more closely, and it's amazing just what you, what I was missing interaction-wise. ... it breaks things down into simple key stages. It isn't about blaming either the parent or the child, and it helps you look at, OK, well the child's not eating, but that isn't really the problem, we need to look at the interaction here...* (HV 3.71:139-146)

Furthermore HV 3.07 who found out about the NCAST pilot work during her health visitor training course regards it highly, emphasising its move away from purely information gathering towards a two-way process of assessment. When questioned about how families feel about being scored, HV 3.71 says it very much depends on how the NCAST is presented to families and she stresses to parents that it "*isn't an exam*" and the focus is very much centred on what the professional can offer the family. She says that only six health visitors in Site C are NCAST trained because of problems in funding the six day training course and instruction manuals.

The diversity of local assessment frameworks in existence in Site C is evidenced further when HV 3.53 who works in a different locality in the Trust describes the presence of yet another assessment tool which combined a series of questions to profile family health needs with a scoring system:

> *... It isn't one that we have to use, it's used on discretion but there are a lot of questions that you really do feel as if you're putting somebody under a microscope and I do find it very difficult to use ...* (HV 3.53:224)

She describes the potentially intrusive and probing nature of some of the questions within the guideline and clearly feels uncomfortable with its crude content. "*You feel a little bit when you're doing it, that it's a bit of the third degree ...*" (HV 3.53:233). It is interesting to find that both this health visitor and HV 3.89 said that in practice they do not use any guideline:

> *You know I've got a mum, actually the one that we're going to see and you know she's told me about her drink problem. It's come out but I don't know that if I'd have gone through that tool of questions that she actually would have acknowledged it at that time.* (HV 3.53:244 – 246).

Similar concerns surrounding the use of such guidelines have been highlighted recently in the nursing press. Health visitors working in a London Trust have been threatened with disciplinary action for failing to utilise an assessment tool containing similar intrusive questions (Coombes, 2000; Nursing Times Letters, 2000; Community Practitioner News, 2000).

6.3 A core programme of contacts – the core child health review programme

The presence of a core programme of contacts closely linked to child health review programmes appeared to be a significant feature in all three sites (See Table 6.1). Core programmes outline the structured visiting protocols existing in each Trust and offered to families with pre-school children. Although not a formal guideline to assist in the identification of families in need, most health visitors seemed to regard any client contacts outside these programmes as an indicator of families receiving extra health visiting. As HV 1.82:591 comments "*we would call it high intervention because it digresses from the core programme.*" Health visitors described how in recent years there has been an increasing management emphasis on adherence to such structured contact programmes.

The demands of the core programme differed only very slightly between the 3 study sites. In Site A it consists of a new birth visit, a follow-up contact and contacts at 3 months, 8 months, 2 years and 3 1/2 years. While in Site B the visiting protocol outlines 'routine contacts' for developmental assessments alongside requirements for new birth and transfer-in visits. In Site C the core protocol consists of an antenatal contact, new birth and transfer in visits and "*the set developmental programmes as well throughout the five years so ... you'll be making contact whether it be by home visit or by clinic attendance ...*" (HV 3.89:366-367). However, it is worth noting that this core protocol differed for two participants, one who was working with the Child Development Programme who would visit all first time parents on at least seven occasions. The second was from a Nursing Development Unit (NDU) where all contacts are based on "*assessed need*" apart from the new birth home contact and child developmental assessments conducted in clinics.

Most health visitors regarded the core visiting protocols as having been imposed on them by their employers, with no consultation about whether these contacts were sufficient to assess and meet client needs. Without exception health visitors regarded the core programme as a minimal service resulting in very limited client contact. "*You know it's not even basic really it's scaled down so much* (HV 1.25:304).

There was no evidence as Luker and Chalmers (1990) found that health visitors use a focus on the 'routine' as a way of gaining entry. This may reflect the limited nature of current core programmes and the reduction over the last decade in 'routine' client contacts. Some health visitors described fears about how the core programme could be reduced. For example HV 1.39 was concerned that with the Hall report recommendations (Hall, 1996), the 8 month developmental assessment could be dropped in favour of a contact at 1 year which she regards as too late.

Health visitors believe that managers equate core programmes to the actual numbers of visits that families need and that they are being used to ration services. In Site A practitioners perceived that managers regarded the completion of the core programme as more important than extra support visits to families in need. HV 1.70 comments :

> *... I think in my opinion the Trust seem to have mistaken the core programme for what families, the number of visits that families need. So it's, although it's useful I think it's being used as a guideline to save money ... we have said that we've got to do extra visits. They say they understand that, but the important thing is to get the core programme sorted out.* (HV 1.70:394-399)

Many health visitors felt strongly that limited core programmes impede preventive work with families. One consequence of the core programme is possible conflicts between a professional's judgement about a family's health needs and management demands for 'routine' service delivery. Such conflicts can mask the extent of workloads and as such are potentially disempowering to practitioners.

This health visitor believes the needs of the population are often ignored:

> *... I mean if you look at the contacts that are sort of put down in guidelines ... you'd only probably see someone five times in their life or something you know - but that's always quite difficult when that's put down as the policy and people would look at that and say well they're only doing that many visits so why are they overstretched ... and don't look at the sort of the needs of the population.* (HV 2.06:279)

A further consequence is that health visitors may be unable to respond to, or identify needs early as they are having little or no contact with families. As health visitors have very little time to actively 'search' out needs some families may be falling through the net. Worryingly a minority of health visitors even acknowledged deliberately not responding to client needs because of lack of time:

> *... you know you're visiting someone, they're telling you so many things, and you think well hold on I really can't cope with that now I've got four other families to see today. So you're constantly finding ways of closing people down. ... You know and instead of going back in a fortnight, it's a month before you go back and it's hard for people to start all over again, to relate to you.* (HV 1.70:415-417)

In all sites health visitors indicated that a management assumption exists that clients with needs will contact the service, however several clients described how difficult it can actually be to seek out professional help. When people are feeling particularly low or vulnerable, contacting a professional is not easy. One client explained how much easier it is if her health visitor keeps in fairly regular contact:

> *... it's like a safety net, erm I've got that contact with her. If she wasn't coming out I wouldn't feel that I've got that contact, do you know what I mean? ... And, say next week, if I had a problem, I'd find it hard to ring up about it ... it's hard to explain ... because you don't like to be a nuisance ...* (C 2.06.3:427-435)

6.4 Adapting the core programme

Health visitors appeared to manage the constraints of the core programme in two distinct ways. Some work to their own protocol and make extra contacts routinely for all their clients. This appears to mirror Chalmers' (1993) findings where health

visitors were found to work according to their own practice frameworks that guided how they allocated time resources within their caseload. In the current study some practitioners appeared to have established their own personal benchmarks for visiting. For example HV 1.39 says that she follows the core programme but routinely offers all families with new babies extra contact visits. She states: "*even families I know I still go back three times*" (HV 1.39:753). She feels that the core programme does not allow enough time to get to know a family. This approach is also adopted by HV 3.89.

The second approach to managing the core programme involved health visitors deliberately not adhering to the requirements of the Trust visiting protocol; instead focusing on supporting families with increased health needs. Such an approach ultimately leads to conflicts between professional judgement and Trust guidelines:

> *... the purchasers have – yeah have purchased five contacts per child within the five year period which as you can imagine is nothing ... I mean this one, for example, that we just visited, I've seen them what six times now within two months, yeah and this woman clearly needs a lot of continuous support at least for a while. ... But obviously I mean, many of us are not reaching that in that we are not keeping up with the protocol ... and we're behind because my priority as a professional, and there's a conflict between what's laid on by a market system and what's laid down by my professional code of conduct. I'm trained to deal with preventative health and I'm saying, I can't be running around doing a three month contact on lets say perhaps a mother with a second child who's been through weaning when I have a mother over there who's depressed and the baby isn't doing so well. So there's a conflict between what's being purchased and what your professional judgement is saying to you and it's having to battle between the two.* (HV 1.25:281-289)

Both approaches to managing the core programme are potentially problematic in terms of client expectations of the service. Such deviations could raise client expectations or be equally problematic if clients get fewer 'routine' contacts than the programme outlines. Interestingly only one practitioner, HV 1.82, raised this as an issue.

6.5 Health visitors use of the guidelines in practice

Having examined the existence of formal guidelines in the three study sites, it seemed important to investigate the extent of guideline use in practice. Tables 6.2 - 6.4 illustrate the use of guidelines at each accompanied visit.

Table 6.2: Health Visitors' use of formal guidelines in Site A

Visit	Observed use of guideline	Type of guideline	Pre-home Visit Interview – HV planned use of guideline	Post Visit Interview – HV use of guideline	Client comment about guideline
1.15-1	No	N/A	No	Says has own agenda but open to client's view. Uses own judgement	N/A
1.15-2	No	N/A	No	Says has own agenda	N/A
1.15-3	No	N/A	No	"Just professional judgement"	N/A
1.15-4	No	N/A	No	Completed Health Profile with client "in early days"	N/A
1.25-1	No	N/A	Refers to 2 year check	No. Does not use any guidelines and says assessment is not structured "I just gather information"	N/A
1.25-2	No	N/A	No	No - specifically states no guideline used	N/A
1.25-3	No	N/A	No	No assessment guideline and would not like to adopt a structured assessment	N/A
1.25-4	No	N/A	No	No	N/A
1.39-1	No	N/A	No	Mentions she will undertake Health Profile at next visit	N/A
1.39-2	Yes undertook HP sought parents' permission to do so	Health Profile (HP)	Planning to do Health Profile if mum calm	Yes – discussed use of Health Profile	Feels it's important for HV to know about family medical history
1.39-3	No	N/A	No	No - Professional Judgement	N/A
1.39-4	No	N/A	No	No - Professional Judgement	N/A
1.39-5	No	N/A	No	No - Professional Judgement	N/A
1.70-1	No	N/A	No	No - PJ. But feels a guide on how to make assessment might be useful	N/A N/A
1.70-2	No	N/A	No	No - PJ. Guidelines must have become embedded with her personal experiences	N/A
1.70-3	No	N/A	No	No but HV feels guidelines might be deeply embedded in practice	N/A
1.70-4	No	N/A	No	No	N/A
1.82-1	No	N/A	No	No	N/A
1.82-2	No	N/A	No	No - Assessment focuses on multiple issues	N/A
1.82-3	No	N/A	No	PJ only. "Just my professional judgement"	N/A
1.82-4	No	N/A	No	Judgement and experience	N/A

Table 6.3: Health Visitors' use of formal guidelines in Site B

Visit	Observed use of guideline	Type of guideline	Pre-home Visit Interview – HV planned use of guideline	Post Visit Interview – HV use of guideline	Client comment about guideline
2.06-1	No	N/A	No	No	No
2.06-2	No	N/A	No	No	No
2.06-3	No	N/A	No	Guidelines don't tell HV how to make an assessment	No
2.06-4	No	N/A	No	No	No
2.20-1	No	N/A	No	No	No
2.20-2	No	N/A	No	No	No
2.20-3	No	N/A	To undertake 18 month check	Describes the use of CONI guidelines when a baby	No No
2.20-4	No	N/A	No	Refers to PIG in terms of registering family need after the assessment. HV visit agenda discussed in relation to PIG	No
2.38-1	No	N/A	No	No	No
2.38-2	No - but appears to use PHR as a framework for the visit	Parent Held Record (PHR) framework	No	No	No
2.38-3	No – but PHR visit framework	PHR framework	No	No	No
2.38-4	No – but PHR visit framework	PHR framework	No	No	No
2.77-1	No	N/A	No	Describes placing mum and child in PIG box	No
2.77-2	No uses PHR as a guide for 18 month assessment	N/A	To undertake 18 month assessment.	HV describes some of the problems of PIG	No
2.77-3	No	N/A	No	Relies on own professional judgement	No
2.91-1	No	N/A	No	No	No
2.91-2	No but adopts a structure for 18 month assessment	N/A	No	Describes undertaking 18 month assessment but not using a guideline.	No
2.91-3	No but appears to adopt a structure for 18 month assessment	N/A	To undertake 18 month developmental checks	Describes undertaking 18 month assessment and adopting a structure but not using a guideline	No
2.91-4	No	N/A	No	No	No

Table 6.4: Health Visitors' use of formal guidelines in Site C

Visit	Observed use of guideline	Type of guideline	Pre-home Visit Interview – HV planned use of guideline	Post Visit Interview – HV use of guideline	Client comment about guideline
3.07-1	No	N/A	No	No	N/A
3.07-2	No	N/A	No	No	N/A
3.07-3	No	N/A	No	No	N/A
3.07-4	No	N/A	No	No	N/A
3.49-1	Yes and HV agenda focussed	CDP	Yes	Yes	Thinks some of cartoon material a bit obvious
3.49-2	Yes	CDP	Yes	Yes	Both she and her sister like the cartoon material and she keeps it
3.49-3	Yes	CDP	Yes	Yes	Yes some cartoon material useful
3.49-4	Yes - focuses on own agenda	CDP	Yes	Yes	No
3.53-1	No	N/A	No	No	N/A
3.53-2	No	N/A	No	No - Refers to routine programme of visits	N/A
3.53-3	No.	N/A	No	No	No
3.53-4	No	N/A	No	Mentions wanting to see mother more often than core surveillance programme	N/A
3.71-1	No	N/A	No	Will use local assessment strategy at next visit	No
3.71-2	No	N/A	No	HV refers to having undertaken an NCAST teaching assessment with parents and 2 year old. Will do reassessment at the end of 8 week period of extra support	Parents mention HV having undertaken an 'assessment' with parents and 2 year old - didn't recall name
3.71-3	No	N/A	No	HV said she was mentally going through the local evaluation sheet	Feels there should be more clear guidelines about when HVs will visit
3.71-4	No	N/A	No	No	No

Key to tables:

CDP – Child Development Programme
CONI – Care of Next Infant
HP – Health Profile
NCAST – Nursing Child Assessment Satellite Training Tool
PHR – Parent Held Record
PIG – Priority Index Guideline

It was fascinating to discover that there was little evidence of health visitors using such guidelines in their practice. A major contradiction exists in the fact that even when guidelines are available, the majority of health visitors appear to ignore their presence when making needs assessments. Indeed most health visitors denied using guidelines during the observed contacts.

Of 56 observed home visits, there was evidence in only five visits of health visitors using formal guidelines. One health visitor (3.49) routinely used the Child Development Programme as a structure for all four accompanied visits, while HV 1.39 undertook an assessment using the Family Health Profile with one family. In terms of the Child Development Programme HV 3.49 describes how the programme provides her with a framework for each visit. Indeed each visit was driven by her own professional agenda and she closely followed a structured CDP assessment format, usually in the same order.

In another four home visits health visitors 2.38 and 2.77 appeared to use the Parent Held Record (PHR) as a framework for the visit.

6.6 Making professional assessments without guidelines

In all three sites there were clear indications that most health visitors were not adhering to guidelines in practice. Several health visitors across all three sites described using their own professional judgements in identifying families needing increased support:

> *it is a judgement, and I'm sure different health visitors judge it in different ways, but I think if the parent is coming to you and asking for help with whatever problem then you must supply that help either yourself or through another agency, and ... it's got to be supported help, you know it's no good just doing a one off bit of advice, you've really got to try and follow it through and make sure that whatever you said either worked or didn't work and modify it if it didn't, but it is a judgement and I'm sure as the years go by you get more experienced at it ...* (HV 1.15.4:93)

One health visitor suggested that assessment involves using a combination of professional judgement and guidelines that have become unconsciously embedded in

practice. Where formal guidelines do exist, as in site B, it became evident that health visitors make a judgement prior to categorising need within the guideline framework. This type of guideline does not assist the health visitor in making an assessment about the family's health. So in effect a judgement has already been made prior to categorising the family within the Index system.

In view of the fact that formal guidelines were present in two areas for identifying families needing increased support, it seemed pertinent to consider why health visitors continue to make assessments without reference to formal guidelines. There is a view amongst some health visitors (although not all) that formal guidelines might be useful for newly qualified health visitors with little experience of assessment:

> *I would have said in the normal run of things yes it's very useful for newly qualified staff and that the more experienced staff I feel probably wouldn't need to use such a tool, that it's something that they would know, their professional judgement would have developed.* (HV 1.82:508)

HV 3.07 describes how as an inexperienced health visitor she used to "*go in armed with records that I had to fill out.*" (HV 3.07:292). Thus there is an implication that as practitioners become more experienced they do not need to use such tools, relying instead on their own judgement when making professional assessments.

6.7 Involvement of health visitors in guideline development

The preliminary study data indicated that guidelines are often introduced because managers genuinely believe that this is a good thing to do to ensure consistency of approach amongst health visitors. In the current study however, there is little evidence of practitioners being involved in the development of guidelines to identify families in need. Only one health visitor, HV 3.71 describes her involvement in the development of a Local Assessment Framework. Furthermore a level of contradiction exists when, as in Site C, health visitors were clearly unaware of the existence of the formal guidelines that had been introduced by managers. This appears to illustrate an example of the theory practice gap. As Grimshaw and Eccles (1998) point out, when practice guidelines are developed it is reasonable to expect representation from

potential users on the development group. One explanation for health visitors not adopting guidelines in practice may be due to their lack of involvement in guideline development, reflecting non-ownership of both the process and product.

Other health visitors are generally critical of guidelines for interfering with professional skills. Some criticised guidelines incorporating scoring systems suggesting that they are not necessarily helpful in addressing family health needs. One health visitor describes a scoring system she became familiar with when working in a different Trust:

> *you can have a mother who is a single mother who has three children and lives in temporary accommodation who manages very well, ... what is more significant is how she, you know, her state of mental health I think at that time, you know, whether she's, whether she does feel in control of it, whether she is able to cope with it. Sometimes you can meet somebody who can and you can meet somebody who equally can't so, ... although they will both score the same, one will be in need of intervention visits and support and the other one doesn't need you.* (HV 1.82:492)

This health visitor describes how she believes lists of risk indices are limited and that she would need to assess a parent's coping mechanisms, as well as levels and sources of support. Another health visitor felt worried that she may miss things by using a structured guideline:

> *... I think that if you're going to use a structure, you're likely to miss a lot of things... Because if you are going by a guideline, it's a checklist you're ticking off. And I think you can miss an awful lot ... my perception is that you'd be strait jacketed to a piece of paper ... and I'm worried that you miss vital observation ... non-verbal cues and, and where you should be using the skill of listening, you may miss something ...* (HV 1.25.3:244-248)

6.8 Summary

This chapter has described the different guidelines existing in the three case study sites for the identification of families needing extra support. An important feature of the analysis is the variety and range of guidelines in existence. This diversity was particularly evident in study Site C. Furthermore in practice several contradictions and tensions exist for which the guidelines are a focus. Firstly the impact of core

visiting protocols in providing a baseline for client contacts, with any contact above this being perceived as an indicator of extra health visiting. Without exception health visitors regarded the universal core programme as minimal provision. This results in health visitors adapting the Core Programme and clearly leads to conflicts between professional judgements and Trust guidelines. Furthermore, the management assumption that clients will contact the service with health needs is negated by data from the client interviews, which reveals how difficult it can be for vulnerable people to seek out professional help.

Despite an NHS ethos of guideline formulation, an apparent contradiction to guideline development lies in their limited use in practice. An overwhelming feature of the analysis was the fact that even when guidelines exist, in reality most health visitors use their own professional judgement in making family assessments. Indeed in Site B, practitioners were very clear that the Priority Index Guideline did not actually help in the assessment of families needing extra support. Instead in this site health visitors appear to make an assessment prior to categorising need within the prioritisation framework. Therefore even when guidelines exist, no accurate predictions can be made about health visitors' actual knowledge of, or use of such guidelines in practice. Furthermore in Site C none of the five health visitors were aware of the formal guidelines that had been sent to the researcher during the preliminary study. This raises issues about the extent to which managers attempt to control practice by not involving field workers in the development of guidelines or practitioners to maintain control by conspicuously ignoring them.

Chapter 7

Challenging Formal Guidelines – The Use of Professional Judgement in Health Visiting Practice.

7.1 Introduction

The previous chapter illustrated the different guidelines existing in the three case study sites for the identification of families needing extra support. An important finding was the fact that despite the existence of formal guidelines, in practice most health visitors described using their own professional judgement in making family assessments. This was especially evident in Site B where health visitors were very clear that the Priority Index Guideline did not actually help in their assessments of families needing extra support. Instead these health visitors appeared to make an assessment, prior to categorising need within the prioritisation framework.

This chapter will begin by exploring health visitors' constructions of professional judgement across the three case sites. While highlighting the overall complexity of professional judgement, the chapter will attempt to explicate some of the central features of this somewhat invisible concept. Indeed health visitors described professional judgement in terms of both a process activity and an outcome or product. The chapter offers a visual conceptualisation of health visitor professional judgement and its relationship to assessment, which will set the scene for a more detailed exploration of health visitor assessment processes in Chapters 8 and 9.

7.2 Health visitors' conceptualisations of professional judgement

A number of participants commented that it was quite difficult to articulate and put into words their understanding of the term professional judgement, because they are rarely asked to explain the meaning of this concept. As such health visitors appear to

be describing a certain tacit knowledge, which Schön (1987) describes as the difficulties that practitioners sometimes face in making everyday practice performances verbally explicit. Schön (1983:49) states that "*every competent practitioner can recognise phenomena ... for which he cannot give a reasonably accurate or complete description*" and he describes this as "*knowing-in-action*". However during the interviews all the health visitors were able to provide their own constructions of professional judgement, although responses were often rather general. Explicitly articulating the basis of experience and the precise sources of knowledge which are used in the formation of judgements did not seem easy. For example one health visitor states:

> *Professional judgement. Right. Erm – it's quite difficult to put these things into words, isn't it? But I suppose to me it means the way I reach my conclusions, taking into account all the things I've been taught, all my experiences that I've had and putting it all together and then coming out with something at the end of it which I hope could be considered as professional.* (HV 2.91:16-17)

Health visitors tended to describe professional judgement as both a process activity and an outcome (See Table 7.1). The process of professional judgement appears to reflect the way in which health visitors form and reach their professional opinions and incorporates a complex process of needs assessment, influenced by knowledge, clinical and life experiences and for some, instinct. Yet the process of making a judgement is seldom scrutinised (possibly because it cannot be observed therefore remaining largely invisible) and health visitors are rarely asked to reflect on this process. Instead in practice it is the outcome (or product), in other words the judgement that tends to be emphasised or measured and which is often the central focus. In practice health visitors tended to refer to professional judgement outcomes and the judgement that a family needed extra support, in terms of professional opinions, conclusions and decisions. "*Making judgements*" (HV 3.07:82), "*making decisions*" (HV 1.25:17) and "*making the right decision for the good of my client*" (HV 2.77:71) were frequent themes in the analysis and reflect the findings of the literature (Chapter 2) where the terms judgement and decision are often used interchangeably.

Table 7.1: Health visitors' perceptions of professional judgement: a process activity, outcome or both

Health Visitor	Professional judgement a process	Professional judgement an outcome	Professional judgement a process and outcome
1.15	✓	✓	✓
1.25	✓	✓	✓
1.39	✓		
1.70	✓	✓	✓
1.82	✓	✓	✓
2.06	✓		
2.20	✓		
2.38	✓	✓	✓
2.77		✓	
2.91	✓	✓	✓
3.07	✓	✓	✓
3.49	✓		
3.53	✓	✓	✓
3.71	✓		
3.89	✓	✓	✓

All the health visitors made judgements about which actual or potential needs they intended to explore with clients during the home contact and essentially these appeared to relate to the initial visit objectives. For example, in the case of one family where there had been "*masses of social services input*" (HV 2.91.3:2) and many ongoing child care concerns, the health visitor described her judgement to monitor the family situation as well as to undertake the twins' 18 month developmental assessment. Such judgements tended to reflect the health visitors' planned processes of needs assessment, although in practice these sometimes altered depending on the client's agenda (See Table 9.2.)

All professional judgements could be broadly classified as process or outcome related (See Appendix 7.1). Judgements may be embedded or closely interlinked, for example a practitioner's judgement to contact a parent in a week's time could lead to further assessment of how a new mother is coping and a judgement about how any expressed needs might be best addressed. In the case of a 3 year old child with a gastroscopy tube and feeding problems, HV 1.25.2 made a professional judgement to

weigh the child monthly at home, as the mother also had a new baby and had difficulty getting transport to the clinic. It is important to recognise that such judgements are not necessarily the end point in a process, for at each subsequent visit it is likely that the health visitor will make further judgements about the child's growth and feeding.

The following health visitors describe the potential complexity of the judgement process:

> *I mean my professional judgement with a particular client comes from a very careful listening of what the client is saying to me and I don't think that can be, can be underestimated really. When I've heard what a client is saying I would then try and check out with them that that is what, that I've got it right, and talk with them about how we might best address the needs that are presented to me* ... (HV 1.82:156-157)

> *I think it's using the skills and the knowledge that you learn in health visiting and keeping yourself sort of up to date with what's going on and actually then utilising that in your judgement of a family, you know, in assessing their needs really and that sort of ongoing assessment, looking at the ... whole family ... actually working with them and listening to their viewpoints ...* (HV 2.06:19-20)

Health visitors' conceptualisations of professional judgement varied very little across the three sites, with practitioners emphasising how they draw on the components of taught knowledge and knowledge gained through life and work experiences. However, as Bryans (1998) previously found in a study of district nursing, the health visitors were more inclined to claim that they use experiential knowledge than taught knowledge when forming their professional judgements. As the following health visitors describe:

> *I think that we should never underestimate experience. Knowledge is one thing, but it can be purely theoretical and I think you need both to be able to be efficient and effective in what you're doing: ... I think life is one whole big experience and I don't think that education is only to be found in educational establishments. I think many of us, although we can't solely rely on our personal experiences, many of us have children, we are home managers and you learn through those experiences.* (HV 1.25:25-29)

> *I think all that I've ever learned in life comes into it, including intuition, which is, difficult to define. But, erm, the job as a nurse, the job as a midwife, the job as a mother at home, family planning nurse, in my particular case. Anything I've taken an interest in, to do with human relationships in and out of work, it all comes together ... you have your antennas out, and it's factual, but it's also a hunch, and therefore, you could get it wrong, of course.* (HV 3.49:56-65)

There was also an emphasis by some of the health visitors on working closely with clients to help them identify and deal with needs as part of the judgement process.

> *To me it means taking into consideration my training and my working experience as well as life experiences and any research knowledge that has come about in dealing with clients and their problems, so you look at it from a broad perspective... You call to mind any erm learning that you have, any new research that's come out and base it on that with your knowledge of people and how you're in rapport with the client to make a judgement on what's happening at the time.* (HV 2.38:24-26)

Figure 7.1 displays a visual interpretation/representation of the health visitors' thoughts and constructions about professional judgement developed through discussions with and observations of health visitors in practice. There was a shared sense of feeling amongst the health visitors that they draw on skills and knowledge from a wide range of experiences when making needs assessments and forming professional judgements. "*Keeping yourself sort of up to date with what's going on*" (HV 2.06:19) was deemed important, as well as drawing on evidence from research. Skills and knowledge may be drawn from many sources including initial nurse training, health visitor and other specialist training, nursing practice, health visiting practice and life experiences. It is an amalgamation of these factors which appear to influence how a practitioner conducts a professional assessment and forms their professional judgement(s).

This health visitor stressed how important the knowledge and skills she had gained from her general nurse training were in helping her to form professional judgements:

> *well anatomy and physiology, knowing the mechanics of how things work normally and how sometimes they can go wrong, you know if it's a feeding problem with a baby then obviously knowing the mechanics of what happens when food goes in the mouth and where it goes. If I wasn't a nurse how would I know that?* (HV 1.39:45-49)

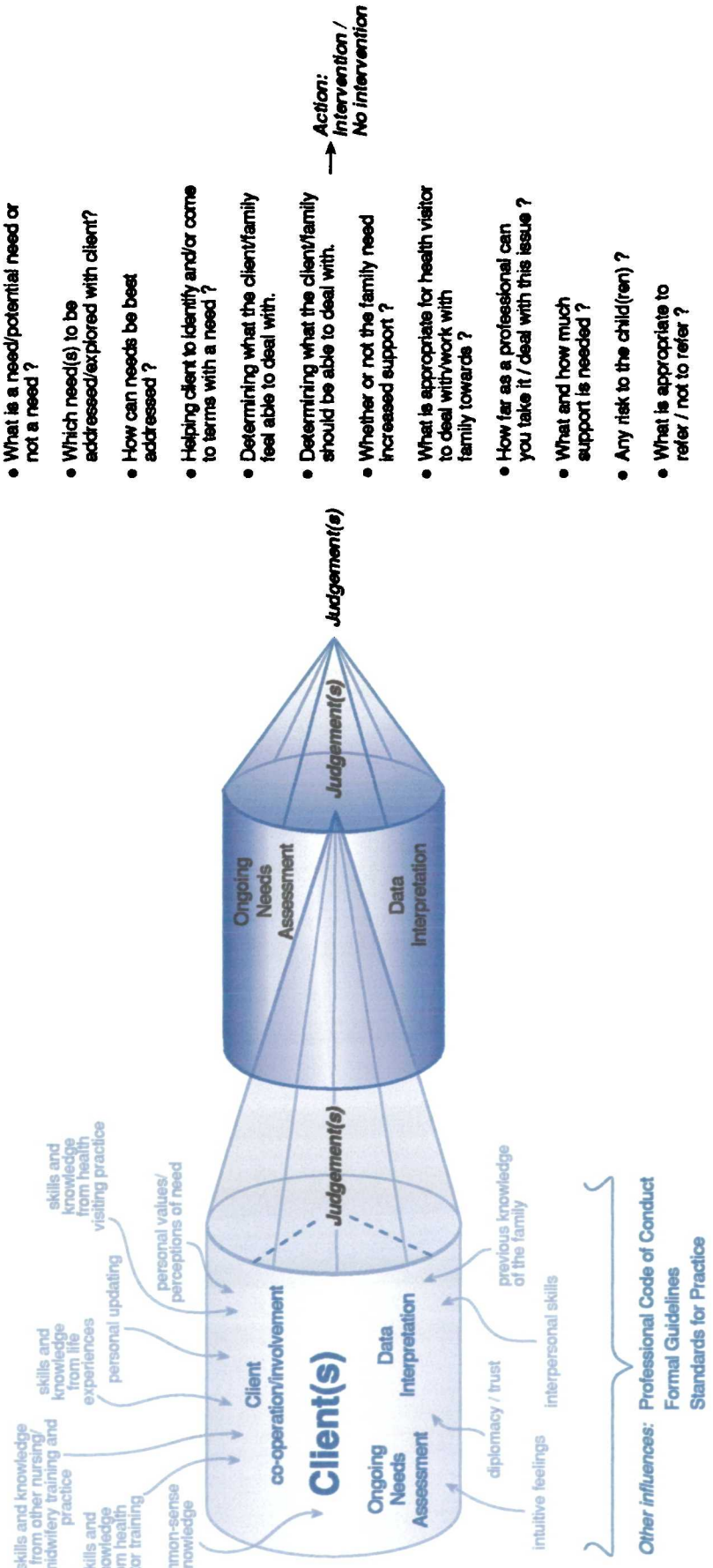


Figure7.1: Process of health visitor judgement formation

During the initial interviews, health visitors largely described the specific sources and nature of knowledge in very general terms.

Table 7.2: Health Visitor Employment Details/Experiences

Site	Years worked as health visitor			Years worked in this Trust			Time in current caseload		
	Range	Mean	Median	Range	Mean	Median	Range	Mean	Median
Site A	3 5yrs - 20·5yrs	10.27	8.0	1.67yrs -18·5yrs	8.6	5.33	2.33yrs -11yrs	4.13	3.0
Site B	3.25yrs - 20yrs	8.62	5.0	0.34yrs - 21yrs	11.38	15.0	0.33yrs -15yrs	5.32	5.0
Site C	2yrs -14yrs	6.5	3.0	1.5yrs - 14yrs	6.4	3.0	0.67yrs - 6yrs	2.6	2.75

Table 7.2 provides a summary of the health visitors' employment experiences across the three case sites. Unsurprisingly virtually all the health visitors believed their previous health visiting experience influenced the process of judgement formation, yet only one described how practitioners could still make judgements with little practice experience:

> *... experience, I think that's important. But sayin' that, I think as a newly qualified health visitor you would be able to make some ... judgements, appropriate judgements even though you haven't really had that much experience.* (HV 3.89:71-72)

When, during initial interviews the researcher explored the concept of professional judgement with participants, only three health visitors described Trust guidelines aiding their professional judgements. It is also interesting to note that during these initial interviews, three of the health visitors working in Site C and one in Site B described professional judgement in terms of gut reaction and "*a lot of intuition really*" (HV 3.71:52). Two health visitors described drawing on hunches and intuition as part of the process of forming a judgement, while the others equated professional judgement with a "*gut reaction*":

> *... I mean gut feeling, really is what comes to mind. It's when you, you're worried about a family and there might not be anything that you can put down on paper what you're worried about ...*" (HV 2.20:40)

Later when practice was observed and then examined during the post-visit interviews, a small proportion of practitioners indicated that they had experienced gut feelings as part of the assessment process (Appendix 9.2). These intuitive feelings appear to be

linked to health visitors' levels of concern about certain family situations and may be influential in how some practitioners form judgements.

Only one health visitor was critical of the value of professional judgement in health visiting practice:

> *For me, on one level, it means an awful lot of bias, a lot of extras coming into judgement, be it own perceptions of need, own perception of what family life should be like, and parenting and what that should be like, so I think for health visitors professional judgement is full of bias, and it varies from place to place, but also the other side to that is ... I take it to mean about drawing on expertise, previous knowledge a lot of intuition really.* (HV 3.71:50-52)

In terms of bias she said:

> *I think that there's a danger of, of a professional bringing in their own feelings, their own points of view, their own, what's the word - value judgements, really, they might have preconceived ideas of what, say, parenting should be like, this set, ideal model, if you don't come up to scratch, really, you might be deemed as an unfit parent, or your parenting skills might be sort of seen as, as inferior.* (3.71:62-64).

To overcome problems of biased practice this health visitor emphasised the need for good clinical supervision:

> *I think you need to have good supervision, and you need to be made to really challenge your own thinking, to be made to reflect on your practice, reflect on your thinking, reflect on your judgement ...* (HV 3.71:66).

7.3 A series of judgements

Health visitors in all sites described conducting a needs assessment as part of the process of forming a judgement. The components of assessment will be scrutinised in more detail in Chapters 8 and 9, in an attempt to uncover the detailed elements of this process. However it is interesting to point out that rarely is judgement formation an isolated event, instead the analysis suggests that health visitors often make a series of judgements about a family situation.

As this health visitor describes:

> *Oh, professional judgement, well I suppose it's drawing on your skills and knowledge that you have to really judge first what's a problem and what's not and to judge how far you can take it and when it's appropriate to refer on and what's appropriate for a health visitor to deal with and what's not, but it's also the judgement about confidentiality and how much you can do for a family and how much they perhaps should - the boundaries where they should really be able to sort some things out for themselves and you point them in the direction and leave them to it and the perhaps more vulnerable members of society like* [Client 1] *that we've seen today who you probably are going to have to prop up for a long time to come, on and off. So I suppose off the top of my head that's what I see professional judgement as.*
>
> (HV 1.15:35-37)

In all the accompanied visits health visitors reported forming at least two or more judgements. Furthermore it is only when a health visitor openly discusses her/his judgement with a client, that it is possible to determine at which exact point in the health visitor/client encounter that a judgement is shared. However, it is likely that the complex cognitive processes informing judgement formation precede its being shared with the client and highlight the difficulty in examining this cognitive function. Of note, only one practitioner, health visitor 3.53 rarely appeared to share her judgements with clients. Yet the circumstances when health visitors share or not, appear on the whole to be to do with the judgement, rather than the health visitor or client.

Appendix 7.1 provides an illustrative summary of the individual judgements that health visitors recognised they had made about the accompanied visits. It is interesting to note the varying number of judgements made, with one practitioner apparently making as many as 17 judgements about a single client contact. Judgements also varied in their nature, magnitude and importance.

7.4 Sharing professional judgement with clients

In trying to determine the extent to which clients are involved in the judgement process, it is interesting to note that health visitors' judgements are not always shared with the client (See Appendix 7.1). Indeed judgements about client need, or the potential need for continued support are often not openly addressed, yet in many cases

there appeared to be an implicit understanding on the client's part that they were receiving extra support (This will be explored further in Chapter 10).

7.4.1 Judgements relating to intended processes

The extent to which judgements were shared with clients appeared to vary depending on different circumstances. When health visitors made judgements about planned processes relating to needs assessment, in the majority of cases these judgements were shared with the client. Sometimes health visitors would share their judgements openly – to the extent that a practitioner would ask "*how are you coping with the children?*" (O 1.25.1:209), or in the case of a mother who had burst into tears in the clinic, because she was finding it difficult to cope with her baby not sleeping, the health visitor said:

> *So when you saw me at clinic* [mother's name] *you, you were very concerned about his sleep. You looked as though he was causing lots of problems for you. Do you want to just tell me a little bit about what's happening?* (O 3.71.4:79-81)

However, in most cases health visitors explored an actual or potential need with a client using skilled conversation without explicitly stating the intention behind the need being assessed. Indeed to have done so would probably have interrupted the practitioner's thinking processes and disrupted the flow of conversation between client and practitioner, possibly even changing the nature of it. For example HV 1.15.3 adopted this sort of informal strategy to make an assessment of how a mother who had a history of puerperal psychosis was coping with her children and to determine the support that she received from her parents. In other situations, health visitors would share process judgements with parents by making their assessment of children visible to parents or through general discussion – "*let's weigh him, see what his weight's doing*" (O 2.20.2:136). Health visitors sometimes adopted both approaches in the same visit.

In the minority of cases when health visitors made judgements about planned processes that were not shared with the client, it appeared to be because the content of the judgement might have been perceived as threatening to the client. These

judgements often centred on monitoring or "*keeping an eye*" on the family, assessing the presence of new carers, the mother's mental health or assessing the interaction/bonding between parents and children.

7.4.2 Outcome judgements

It became apparent that there was a tendency for health visitors to share outcome judgements with parents that focus on positive aspects and which can largely be regarded as safe, non-threatening and acceptable to clients. For example, health visitors never openly shared their concern with a parent that a child might be potentially at risk. In one situation, where a health visitor was concerned that a mother with a three-week baby could be at risk of post-natal depression she did not let her concern show. Instead she tried to boost the mother's confidence, reinforcing and praising how she was learning about and coping with her new baby daughter.

Health visitors also avoided sharing judgements that a parent is not coping. As one practitioner described:

> *it's one of those situations when there's a very fine line between telling somebody you're concerned about their ability to care for their baby and sort of holding the information and waiting and seeing what happens later.*
> (HV 1.39.2:61)

This strategy reveals an element of risk taking and a confidence to do so.

Health visitors also appeared to avoid conveying a negative message to a parent, trying instead to identify positive aspects in a situation. For example HV 1.15.4 had been supporting a mother with a baby with sleep problems but during the accompanied visit it became apparent that having followed the health visitor's advice, the baby's sleep difficulties had resolved. The health visitor was obviously pleased yet surprised that things had progressed so well. She felt it was likely that the situation could deteriorate and the baby's sleep difficulties could resume, yet she avoided sharing this judgement with her client, wanting instead to focus on the progress that the family had made in order not to demoralise the mother.

Exceptions to this finding appeared to be when health visitors wished to convey to a client that they recognised the needs being faced by the client, in order to legitimise their feelings. When HV 1.39.3 shared with a mum her judgement that she was depressed, the client was clearly relieved that someone has recognised the depth of her need. However, it is interesting to note that this health visitor did not reveal the full extent of her concern to this mother and this was a common strategy evident in the data. In such cases health visitors seemed to carefully balance the degree to which a judgement was shared and this seemed to be influenced by the practitioner's degree of personal knowledge and level of rapport with a client.

Also at some stage nearly all the health visitors made a positive judgement which was not shared with their client. Furthermore when health visitors reflected on and viewed their own practice either negatively or with certain limitations, these judgements were not shared.

Many shared judgements centred on health visitors conveying the result of their assessments to parents about a child's developmental progress, or the need for a referral or in a small number of cases to acknowledge a problem, such as a baby appearing unwell. However, a common thread was that many outcome judgements shared with parents centred on acknowledging how well the parents were doing, in either the progress they were making or reassuring them about their parenting abilities.

In this research the professional judgement that a family needed extra support was usually made fairly swiftly and was often quite obvious to the health visitor, but uncovering the full range of associated needs invariably took a lot longer. Judgement sometimes incorporated a view about the urgency with which a need must be dealt with thus encompassing an element of prioritisation. This prioritisation centred on whether the need actually existed or was a potential need, how it was being managed and the interventions or referrals needed to help deal with the need. It sometimes also incorporated an element of helping a client/family to identify their own needs.

To conclude this chapter offers an abstract definition of professional judgement that has emerged through data analysis:

> Health visiting professional judgement incorporates integrated and interrelated elements of process and outcome. It can be described as a professional opinion or conclusion which includes assessment of health need and is reached following an accumulation and careful deliberation of evidence; it is informed by a broad spectrum of professional and life experiences, knowledge, instinct and common sense.

7.5 Summary

This chapter has provided an overview of the health visitors' constructions of professional judgement. Indeed there appeared to be considerable consensus amongst practitioners working across the three case sites. The chapter has offered a visual conceptualisation of health visitor professional judgement and its relationship to health visiting assessment processes. The health visitors participating in the study described professional judgement in terms of both a process activity and an outcome or product. The judgement process appears to incorporate a complex and sophisticated process of needs assessment, influenced by a range of knowledge, clinical and life experiences and for some, instinct. These processes will be explored in more detail in Chapters eight and nine. Judgement formation is rarely an isolated event, instead health visitors appear to make several judgements about client and family situations, which varied in their degree of importance.

Chapter 8

Health Visiting Assessment Principles

8.1 Introduction

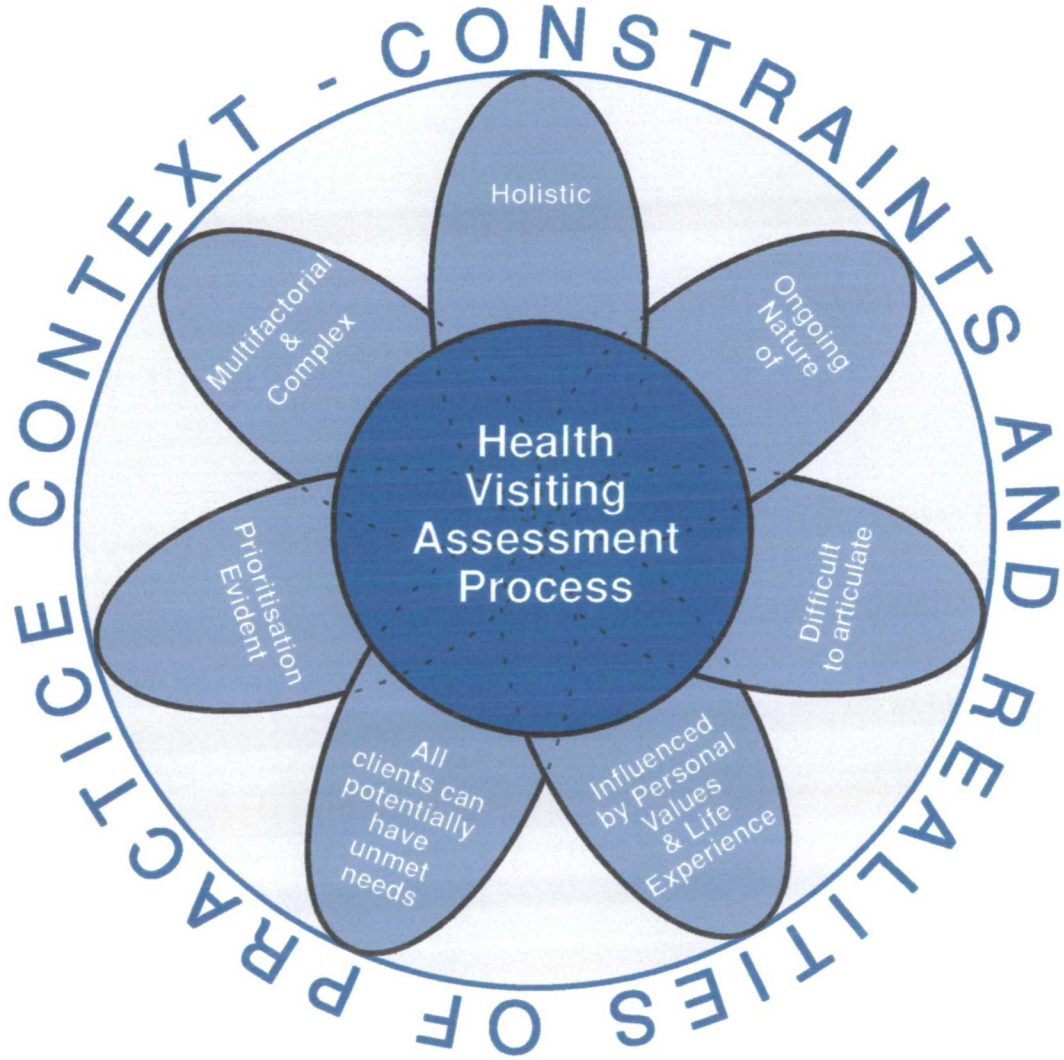
Chapters 8 and 9 will present a description of the health visiting assessment process, developed through discussions with and observations of health visitors and their clients in practice. These chapters will attempt to explicate the various elements associated with the processes of identifying and assessing family health needs. They will endeavour to unravel some of the complexity of health visiting assessment processes. The analysis suggests that health visiting assessment is a complex, interactive and serial activity, with health visitors' co-ordinating information from a variety of sources in order to assess family health needs and formulate professional judgements. There appear to be certain fundamental elements associated with the majority of health visitor assessments and these have been termed assessment principles. These characteristics appear inherent to the nature of assessment and will be examined in detail in this chapter. They reflect the basic principles of health visiting assessment practice which exist despite the constraints and realities of the practice context and can be differentiated from the activity centred methods of assessment processes.

8.2 Assessment principles

An important feature of the inquiry were the seven fundamental principles which emerged through data analysis, these features appear central to health visiting assessment and continually surfaced in the data. The seven assessment principles are shown in Figure 8.1, which attempts to illustrate their integrative nature and synthesis. Indeed some of these attributes have been identified in earlier research

work (Wheeler, 1989; Appleton, 1993; Bergen et al, 1996a). It is also worth pointing out that the principles and their attributes are not all of the same order, with 'Difficult to articulate' and 'Influenced by personal values and life experiences' being about the health visitor, whereas 'holistic', 'multifactorial' and the 'ongoing nature of assessment' are about health visiting practice. 'Prioritisation' appears to be dependent on both organisational influences and practitioner judgements, while the potential for clients to have unmet needs centres on the client experience.

Figure 8.1: Health visiting assessment processes: Essential principles



8.2.1 Holistic assessment

The data clearly highlighted that health visitors' assessments are holistic in nature involving a focus on the whole situation, not a single problem or issue, as Bergen et al. (1996a) also found. Indeed HV 3.89 described how her health visitor training course had emphasised such a holistic approach. The previous chapter illustrated how the process of making a professional assessment appears to involve a series of judgements rather than a single or isolated judgement. It is a complex and skilled process and encompasses the co-ordination of assessment data from a variety of sources. Without exception during the 56 observed home visits, health visitor assessments never focused on a single health need, instead multiple needs were addressed and a holistic approach adopted. As one health visitor summarised, it's "*the whole scene*" (HV 3.49:80), "*it's a hundred little things*" (HV 3.49:98).

A number of health visitors described how although the child is often perceived as the central focus of health visiting, parental problems and needs are often closely intertwined with the child(ren)'s health and developmental needs and as such cannot be ignored: "*it isn't just visiting babies, it is as I say holistic health visiting ...*" (HV 2.77:115).

It was evident that many of the health visitors did not confine their health visiting work to the under-fives and their parents. Many viewed their role as a 'family visitor' and as such would not restrict their practice to work with pre-school children, one health visitor even enquired about the family pet:

> *... we're talking about the health of a whole family rather than just one child. It's not just one child in isolation, it's what happens when that child goes home and what the impact is for the rest of the family and it seems to me that you can't say well I'm the health visitor for this family because there are children under the age of five so therefore I've got to ignore the ones in school that are the parents' real concern, and you know because you're the family health visitor and not just the health visitor for the under fives you do get drawn into these things.* (HV 1.82.2:197)

It was interesting to find that the primary focus of many visits was not a child but an adult (See Table 8.1).

Table 8.1: The central focus of the visit

Area	Mother	Child(ren)	Parent(s) and child(ren) Family focus
Site A	1.15.1º 1.15.2 1.15.4 1.25.1 1.25.2 1.25.4º 1.39.1 1.39.2 1.39.3 1.39.5 1.70.4 1.82.1º 1.82.4	1.25.2	1.15.3º 1.25.3 1.39.4 1.70.1 1.70.2º 1.70.3 1.82.2* 1.82.3
Site B	2.06.2º 2.06.3 2.38.1 2.38.2º 2.38.4 2.77.2 2.77.3 2.91.1 2.91.2º	2.20.2 2.20.3* 2.38.3 2.91.4*	2.06.1º 2.06.4 2.20.1º 2.20.4* 2.91.3º 2.77.1*
Site C	3.07.4º 3.53.1º 3.53.2º 3.53.4º	3.07.2 3.71.2* 3.71.4	3.07.1º 3.07.3* 3.49.1 3.49.2* 3.49.3º 3.49.4 3.53.3 3.71.1 3.71.3
TOTAL	**25**	**8**	**23**

* Father/boyfriend present for the duration of the visit.
º Living as a single parent family

Some might argue that as practitioners involved in the protection of children, this might indicate professionals "loosing sight of the child" (Ayre, 1998:33). However, a recurrent theme raised by the health visitors in this study was their intent on recognising and addressing parents' needs - 'working through the parents' in order to fully promote a child's health and well-being. Many health visitors emphasised the central role played by mothers in particular in maintaining family stability and well being. The mother was

viewed as the key figure in most families and health visitors continually described their attempts to provide support to these women. They attempted to promote the importance of the mother's role in the family by acknowledging and getting mothers to recognise their own needs. As one health visitor describes:

> *I feel that I have ... raised awareness of her own self care ... and how it influences her life ... because that is the backbone of the family ... if she is well and looks after herself and has the energy level sufficient then she's more likely to see the child's needs, to be patient and inventive and, and able to provide ... I'm a health visitor because I like to help parents, not because I love little children, the children are not as important to me as the mother. And I feel she is the key in most families, the key person and if she is well her children will be well and if she is neglecting herself, foodwise and otherwise, the children's health will suffer and in the end ... If the child then suffers because the mother suffers I have to shift my loyalty from the mother to the child.* (HV 3.49.4:117-125)

The data presented in Table 8.1 negates Fawcett-Henesy's (2000:747) recent, yet unsupported claim that health visitors:

> *focus on the child and the mother but the research evidence does not say they look at the family. They will tell you they are family health visitors but the evidence says they focus on the presenting problem.*

Furthermore when just under a third of the families in the study constitute a single parent family, health visitors will inevitably focus on maternal and child health needs.

Health visitors clearly recognised that parenting is not an easy task and would work through the mother, in an attempt to offer support and nurturance, to build up her resources in order to offer support to the whole family. There was a general view amongst the health visitors that mothers may find bonding difficult if their own emotional needs are not met. A common thread throughout the observed home visits was the need to provide emotional support to women:

> *I think a lot of our work is concentrating on the emotional quality of people's lives ... and take for instance if I visit a young family, a new mother ... with a small baby, I look at how the mother's bonding with the child and ... I don't think she can bond properly when she's got her own needs to fulfil, so what I look at, quite often I look at mother's needs.* (HV 1.70:116-118)

Likewise HV 2.38.1, when describing the extra support that she was offering a young mother who was feeling particularly isolated on a new housing estate, stated: *"she needed that nurturing for herself at that time"* (HV 2.38.1:195).

This health visitor went on to describe how, from the children's point of view her support to the mother was an "*early intervention preventative measure*" (HV 2.38.1:203). She was concerned about the potential for the children to be neglected or to be deprived emotionally, as the mother became more short tempered, shouting at the children and less likely to control her actions. In this family situation health visiting interventions centred on helping the mother to recognise her own needs, while boosting her confidence levels and own self-esteem and making her feel important as an individual person.

Other health visitors described how parental bickering and personal relationship difficulties can have a knock on effect on their child's development and/or behaviour, resulting in negative outcomes for the child:

> *I mean this is sometimes where you might be able to pick up that maybe the child's speech isn't developing very well, but then is that because mum's almost never talked to this child. So you can often sort of move in sometimes through the child and pick up some of these underlying problems which at the end of the day you're there to protect the child and give the child maximum benefit from the services that you're offering ... but you've got to work through the parents generally to do that so but you're really there for the child rather than to sort out the parents' on-going long standing problems but the two are so intertwined sometimes that you know you have to deal with both ... although the child is paramount and central you are actually there as a whole family visitor.* (HV 1.15:186-191)

Even when a home contact initially appeared to have a single central focus, health visitors did not limit their assessment to the single issue but invariably addressed associated needs or examined its wider impact. For example HV 1.39.4 was asked by a mother to visit her home because of the worsening problem of pigeon excrement and smell caused by an influx of nesting pigeons in her council tower block. Despite the public health issues around the odour and mess of the pigeon excrement, the health visitor attempted to examine the impact of this issue on the whole family's

health. She explored issues around lack of ventilation and overheating in the flat because of not being able to open the windows, the potential dangers of a 10/52 old baby becoming overheated, mum's anxiety about the baby being grizzly and unwell, her depression about the pigeon situation and how it was affecting her relationship with her husband, as well as assessing the development needs of her 3 year old daughter.

The notion of the holistic assessment also became evident during some home visits, where observation data revealed that some health visitors attempted to make a logical assessment of each family member in turn, through a combination of discussion, observation and/or physical assessment. This compartmentalising of assessment was often a feature of very 'busy' visits, where several family members and sometimes other individuals were present; it was also an approach used by the one health visitor adopting the Child Development Programme.

> *I mean I always like to do one child before I, I think because otherwise, parents can cross you over and then you get totally lost. So it's better to start with one child ... and I usually start at the top and work down in a child ... I do have a sort of routine, then I don't miss anything ... however many children ... I do one and finish with one before I go on to the other ... So yes ... I do have a sort of logical way of doing it. But it's all in my brain.* (HV 2.77.2:103)

This approach was evident during a visit to a family with 5 month old triplets where HV 1.50.1 weighed, physically assessed each baby's development and talked about their progress individually, in turn. Another health visitor explained how she tries to make an individual assessment of each child in a situation and when reporting this to me, described one child at a time. This health visitor recounts how with one family there have always been three strands to her assessment:

> *There'll be I suppose like three threads there really and that's how it's been every time I've visited you know. ... even like this morning you know there's the three components there. There's the baby and there's* [Mum] *and it's usually started off with* [Mum]. *Then we went to the you know talking about the baby and the diarrhoea, we talked about* [9 year old] *and* [13 year old] *and whatever, so there's always those sort of three sort of strands to every visit then and – that can make it quite complicated ...* (HV 1.82.1:91)

A further feature of the holistic assessment was the attempt frequently made by the health visitor to co-ordinate assessment data sometimes gathered over a period of time, pulling together information. De La Cuesta (1992) has previously described such an approach in a study exploring basic social processes in health visiting, she says assessment "*involves a gestalt process where previous and present information are combined to form a picture that includes more than the sum of its parts.*" Health visitors in the current study continually provided examples of how they attempted to combine assessment data:

> *... the knowledge that I've gained about the family over the time that I've visited because I've probably visited quite a number of times since actually making that contact from last year. So I've actually gathered a lot of ... knowledge about them in sort of in the different situations that I've seen* [Mum] *in – from varying from literally sort of being subjected to violence from her partner to – the visit today where I felt that things were sort of quite settled and stable. And it's, it's being able to look at that family as a whole and the different situations that she's actually been in ... sort of getting to know the children – seeing sort of how they've progressed with their development and the behaviour as they're growing ... and it's really being able to put that together to make an assessment as to whether you feel that, at the moment the children are receiving the adequate standard of care, the stimulation.* (HV 3.53.2:238-240)

8.2.2 Assessment is a complex and multifactorial process

A probable consequence of health visitors' assessments rarely focussing on a simple or single issue, is the multifactorial and often complex nature of the assessment process. As HV (1.82:398) states "*I think it's often a combination of factors*" which influences her judgement to offer a family extra intervention. Thus assessment appears to incorporate a multiple perspective with a practitioner registering and considering several factors apparently simultaneously. As this health visitor describes:

> *I looked at the baby's motor development, was he weight bearing, was he doing with his arms and his legs basically, is he doing what he should be doing, erm I looked at, is his speech and language development appropriate for his age, vision and hearing what was he doing, and his social behaviour so it was really an overall assessment of whether the baby had reached milestones for his age ... I also assessed by observation and what the mother was saying, her relationship with the baby, was she relating with the baby, whether the baby was being stimulated ... I tried to assess her mental state, her physical state, in terms of is she getting sleep, is she eating.*(HV 1.25.4:138)

This multi-factorial process of assessment appears to involve a range of skills, and knowledge including advanced interpersonal skills. The importance of recognising and acknowledging both verbal and non-verbal client cues was repeatedly emphasised by the health visitors. This health visitor describes how on entering the family home she immediately recognised a post-natal mother's distress, by rapidly interpreting the information presented to her.

> *As soon as we went in it was obvious that she was distressed ... she looked anxious, she looked very upset, she looked quite tearful she started to talk straight away about you know how she was feeling as though she was actually waiting for us to go in and like offload. The house, as soon as you walked in it looked quite chaotic there were things all over obviously she was finding it difficult to cope with you know the child care and also with the house and also her own feelings, so it seemed quite obvious at the time things had got difficult to manage ... I could actually look at the house and the conditions and actually assess how she's feeling... It goes hand in hand with that ... When things are bad the house just goes to pot and when things are good the house is spotless, it really is really clean. Erm and then we started to talk and it became clear from listening to what* [Mum] *had got to say that the main problem for her at the moment was about her own parents, about her mum in particular and comments made about her and her parenting, by her mum and her aunt, which obviously were very upsetting for her ...* (HV 3.71.1:104-114)

The above extract highlights the multi-factorial nature of the health visitor's assessment, yet it is worth noting that there is little previous research evidence detailing the nature of these processes. Indeed the skills required for such an assessment are often overlooked. In an attempt to address this shortfall, Chapter 9 will explore further the detail and intricacies of health visitor assessment processes. Such complexity may be one reason why practitioners find it difficult to explain what they are doing in practice. A further feature of the complexity is that a lot of assessment activity is actually invisible to clients as practitioners conduct assessment in such a sophisticated and integrative way. As one mother commented on her son's 18/12 developmental assessment:

> *I thought she was just going to come and chat, to see if there were any problems. I didn't realise she was going to weigh him, measure him and use all the toys to see his sort of motor development, because she does that very cleverly you know, you don't realise what she's doing and she's observing things that you take for granted.* (C 2.77.2:156-157)

8.2.3 Ongoing nature of assessment

As Bergen et al. (1996a) have previously found, the health visitors in this study regarded assessment of family health need as an on-going process, with assessment taking place at each client contact (See Table 8.2). However, some health visitors distinguished between a first assessment "*where you're looking at lots of different ... areas*" (2.06.3:206) and subsequent on-going assessment where a lot of information is already known and assessment begins to focus on a specific need or needs. Health visitors continually stressed the on-going nature of assessment:

> *If you make the assessment and you think that you need to go back, then every time you go back you're reassessing the situation* ... (HV 1.82:231)

The serial nature of the assessment process was particularly emphasised in those cases where health visitors find an initial assessment difficult or where practitioners are unsure about the outcome of their assessment. For example, if a client displays what the health visitor perceives to be inappropriate behaviour a re-assessment may be necessary to confirm this view. One health visitor described how if she is unsure about something she would visit the client again, "*because sometimes it takes two visits to actually get clear in your mind that somebody is more stressed than they would normally be ...*" (HV 1.39:166), she goes on to say:

> *... they may not need more support but if I haven't got it clear in my mind where they're coming from and what they understand and how they're going to be, then I will go back sooner.* (HV 1.39:688).

The potentially informal and casual nature of this process is described by one health visitor as: "*... it's really looking around over a period of perhaps a couple of visits*" (HV 1.15:97)

The need for reassessment appeared to be one consequence of the uncertainty of many family situations. Some health visitors described how "*it can be very dangerous*" (HV 1.15:245) relying on an assessment made during one contact. Many stressed the importance of having the time to build up a relationship with a client in order to make an accurate assessment, arguing that perceptions of people change as you become

Table: 8.2 On-going nature of the assessment process

	Assessment process apparently complete	Assessment process apparently incomplete	Follow-up arranged – planned contact	Follow-up arranged – telephone contact**	Follow-up implied. No contact planned	No follow-up arranged
SITE A						
First home contact with client/family	-	-	-	-	-	-
First contact for new need	1.39.4	1.82.3	-	-	1.82.3	1.39.4
Subsequent contact	1.15.4 1.70.1 1.70.4 1.82.4	1.15.1 1.15.2 1.15.3 1.25.1 1.25.2 1.25.3 1.25.4 1.39.1 1.39.2 1.39.3 1.39.5 1.70.2 1.82.1 1.82.2	1.15.1 1.15.2 1.25.1 1.25.2 1.39.1 1.39.2 1.39.3 1.39.5 1.70.2 1.82.2	1.25.3 1.25.4 1.70.3 1.82.1 1.82.4	1.15.3	1.15.4* 1.70.1 1.70.4*
SITE B						
First home contact with client/family	-	-	-	-	-	-
First contact for new need	2.20.1 2.20.4		2.20.1			2.20.4
Subsequent contact	2.06.2 2.38.1 2.77.2 2.91.1	2.06.1 2.06.3 2.06.4 2.20.3 2.38.2 2.38.3 2.38.4 2.77.1 2.77.3 2.91.2 2.91.3 2.91.4	2.06.1 2.06.3 2.06.4 2.20.2 2.38.2 2.38.3 2.38.4 2.91.4	2.38.1 2.77.3 2.91.1 2.91.2	2.20.3 2.77.1	2.06.2* 2.77.2 2.91.3
SITE C						
First home contact with client/family	3.71.4	-	-	-	-	3.71.4*
First contact for new need	-	3.71.3	3.71.3***	-	-	-
Subsequent contact	3.07.3**** 3.07.4 3.49.1**** 3.49.3 3.53.3 3.53.4 3.71.4	3.07.1 3.07.2 3.49.4 3.53.1 3.53.2 3.71.1 3.71.2	3.07.1 3.07.2 3.49.2 3.49.4* 3.71.1 3.71.2	3.07.4	3.53.1 3.53.2 3.53.4	3.07.3**** 3.49.1**** 3.49.3 3.53.3

* In these cases the health visitor encouraged the client to make contact if needs arose and wished to address these.

** This includes a phone contact to give information to client, contact by phone to review progress of needs or a phone call to arrange a subsequent home visit.

*** Follow-up with another member of the health visiting team.

**** Transferring client to another health visitor.

more familiar with them and get to know them better. Time is required for the health visitor to reassess family situations and to enable clients to tell their story:

> *You go in to build up a relationship so that they can take up the services that are offered.* (HV 1.25.2:Pre-visit interview)

However, health visitors continually described situations where they are constrained by a lack of time because of the demands of large caseloads. As such in reality they often have to make an immediate assessment of a family's health needs:

> *... it's like a lot of people, you have to get to know them and yet you've got to make an assessment on that first visit because you need to look to see whether there is anything particularly outstanding that needs following up, but I think you've got to keep an open mind and allow for the fact that people need to get to know you. They're not all going to be very open and that to a stranger, which is what you are.* (HV 3.53:211-212)

This point was also substantiated by client interview data, with some clients reinforcing the view that they needed to get to know their health visitor and build up a relationship before feeling able to talk openly about their family's health needs. Client needs may thus unfold over a period of time. This was particularly evident during one observed visit when a mother disclosed to the health visitor that as a child, a neighbour had sexually abused her. She later said:

> *... you've got to build up the confidence as well. I mean I know they're all trained and everything but erm I wouldn't have told a complete stranger what I said today, you know.* (C 1.39.3:264-266)

Connected with the issues of relationship building and trust is the fact that sometimes clients are just not ready to acknowledge and open up discussion about their needs, however apparent to the health visitor. Part of the skill of health visiting is about holding back even when a practitioner has concerns about a family situation and waiting until the client is ready to make a disclosure. This seems to be about getting the timing right and may involve an element of risk taking:

> *What I tend to do is I'll actually say to somebody, I don't feel something's quite right here, I'm here, but I'm not gonna, you know, labour the point, I'm here if you want to actually approach me with something, play the ball in their court, really, I've done that quite a few times ... one of my clients who I started being the key worker for, I thought, there was domestic violence, she was covered in bruises, all of the time, and I actually asked about that a couple of times, and whether it's going on "oh not at all, not at all", about two months ago she came here, wanted a hostel place and I've seen the children before, for their needs at home and I was always aware that this was an issue, and I knew in the back of my mind this is why there were problems at home with behaviour of the children, but I got the distinct feeling that she wasn't feeling safe to discuss that, she came here, and said openly, "he has been hitting me, I want to get this place. I want to do this, that and the other, you know, can you help me do it?* (HV 3.71:341-345)

The need for reassessment was also stressed in terms of assessing the outcome of health visitor interventions and the reassessment of agreed action plans.

8.2.4 Difficult for health visitors to articulate how they make an assessment

During post-visit interviews it was often quite difficult for health visitors to articulate and explain the process of making an assessment of a client needing extra support. A few expressed hating this part of the interview, as they are seldom required to make such everyday practice performances verbally explicit and rarely reflect on the minutiae of the process. Many suggested that some aspects of the process are undoubtedly automatic and as such they probably do things without recognising they are doing it: "*you do cover things without realising it and you do it so automatically.*" (HV 2.77:101)

This health visitor went on to describe the tacit nature of this type of knowledge:

> *... I think most people in doing any form of assessment they just do it, they don't think about it. And I think back to Schön in one of his books ... and he's saying that you know professionals do things and you change, you amend, you evaluate as you go because as a professional you, you know ... instinctively if you like ...* (HV 1.25.3:256)

Despite the difficulties associated with describing and putting into words assessment processes many health visitors stressed the importance of health visitors being able to clearly articulate how they make their professional assessments. This seems crucially important in justifying the health visiting role in light of recent policy. One health visitor commented:

> *I think we need to be more vocal about what we're doing, about how we're assessing, what we're looking for, what we're looking at, and how we're actually prioritising. I mean, here, I said before that we visit on assessed need, but even we struggle with, well what do we do when we're assessing.*
> (HV 3.71:70-71)

There is an implicit assumption that health visitor training and education will prepare practitioners to be able to undertake needs assessments competently, although a recent report has raised serious questions about the basic content of some course curricula (Mahoney, 2000; Cowley et al, 2000a). Since the introduction of the Community Specialist Nurse framework in 1995, the length of health visitor training courses have been reduced from 51 to a minimum of 32 weeks (Nursing Times-This Week, 2000). In 2000, the statute was amended to bring it in line with UKCC rules and the Specialist Practitioner framework. Yet despite the increasing complexity of health visiting practice and the current policy emphasis on public health, course content has been pared to a minimum and the situation continues to deteriorate. Table 8.3 reveals that training for needs assessment did vary amongst the participants. It is perhaps surprising to note that this table reflects the totality of data about education for the participating practitioners, from the three study sites. Furthermore little training is available to health visitors once qualified and on the job. In fact the data provided little acknowledgement of the continuing professional development needs of practitioners.

Table 8.3: Health visitor education on needs assessment

Health visitors in Site A					
Education Experiences	**1.15**	**1.25**	**1.39**	**1.7**	**1.82**
Needs assessment input during HV training	No	Read about health needs assessment & Robertson's (1991) health visitor cycle But no formal input	Maslow's hierarchy of needs	Thinks so but cannot remember specific details/focus	Cannot remember
Needs assessment education/training post-qualification	1) Monthly sessions with clinical psychologist 2) At update sessions - indirect feedback on family assessment	No. Input on work of Ewles and Simnett (1995)during health promotion module of CPT training	No	Education re assessment of children's needs prior to school with Education Department. Nil else	Yes input on family needs assessment and scoring systems in a different Trust & input on 'Back to Health Visiting Course'
Health visitors in Site B					
Education Experiences	**2.06**	**2.2**	**2.38**	**2.77**	**2.91**
Needs assessment input during HV training	Yes - focus was the health visitor cycle		Yes	No theoretical input, discussed assessment in practice with Community Practice Teacher(CPT)	Yes
Needs assessment education/training post-qualification	No		Yes in terms of Child Protection Updates and training on developmental assessment with local paediatricians	No	No
Health visitors in Site C					
Education Experiences	**3.07**	**3.49**	**3.53**	**3.71**	**3.89**
Needs assessment input during HV training	Yes - health needs assessment & communication Focussed on Heron's (1975) Six Category Intervention Analysis		Yes	Yes	Yes. Most input from Community Practice Teacher (CPT)
Needs assessment education/training post-qualification	No	Yes input through Child Development Programme training and CDP support seminar groups	Update on Hall Report and health visitor training quite a long time ago	No	No

8.2.5 The assessment process is influenced by a practitioner's personal values

Previous research has suggested that when a health visitor makes a professional judgement, s/he is influenced by personal values and life experiences (Wheeler, 1989; Appleton, 1993) and this was a view held by many health visitors in the current study. It seems likely that health visitors will also be influenced by their personality, by cultural beliefs and attitudes as they draw on personal knowledge and prior experience in shaping their professional assessments. Despite the prevalence of this viewpoint, one health visitor described how she felt that the negative influence of personal values could be reduced if health visitors develop skills in self-awareness, to become more objective and less personal, and to be better able to deal with their own feelings.

Health visitors described the need to recognise that client standards may differ from their own, that people obviously live in very different ways and that there is a need to be sensitive to this fact. This also seems to link to recognition of the uniqueness of individual family situations.

> *... I suppose you do have a basic expectation of what you find in a house but I think you have to, you have to adjust that assessment to standards that you expect in a house and the way that people do live, what's acceptable for one family wouldn't be for another but that doesn't mean to say that it's harmful or wrong in any way and would actually require any extra support. Every family has to be taken on how you find them.* (HV 3.53:99-100)

However, three health visitors did point out that there comes a point when assessing that they do let their own standards influence the assessment process, when a family situation starts to "*interfere with the children's well-being*" (HV 1.82:215). As one describes:

> *You can't place your values on other people. But there comes a stage, it gets to the stage where their standards are just not acceptable because it has an effect on the children in some way.* (HV 1.39:836-837)

Health visitors were also aware of the potential dangers of making early judgements about clients. Where possible health visitors gather background information on a

client or family before making a first assessment, although many were aware of the potential dangers of being overly influenced by this type of background information. Indeed one practitioner, HV 3.89, stressed the potential danger of building up a picture about a client before meeting them that could be wrong. This health visitor describes how she avoids reading family notes until after she has completed a transfer-in visit assessment to avoid being influenced by other's judgements.

Although many health visitors described the importance of being non-judgmental when making family assessments one unfortunate, yet inevitable consequence of assessment practices being influenced by personal values and life experiences is the potential for practice to become judgmental. Some health visitors admitted to being aware that they do make value judgments about some clients. Interestingly three health visitors (HV 1.39, 2.06 and 3.71) did acknowledge making value judgements in their practice:

> *I suppose I do judge people to a certain extent by what job they do I don't think in a, hopefully not in a detrimental way to them, as I say I've got a lot of teachers who I do visit and there's one in particular, I can't remember what her husband does, I think he's a computer programmer or works with computers or something but she's not like the other teachers that we've got.* (HV 1.39:504-506)

Health visitor 2.06 suggests that when working with clients she makes a judgement about the clients she is visiting and alters her behaviour and approach accordingly. However, this ability to work at the client's level did appear to be highly valued by her clients:

> *You know you don't have to speak to her on a different level from what you're on you know you don't have to speak to her as if she's a more upper class person, I don't know how else to say it, or a lower class or you know you can speak to her how you feel...* (C 2.06.2:137)

In practice the apparently judgmental nature of some health visitors was witnessed when practitioners made what could be perceived as derogatory comments. For example during a pre-visit discussion, one health visitor referred to a family as a "*typical vulnerable family lots of rubbish outside.*" In another situation a health visitor

described her client in terms of "*she was a boozer*" and "*I think* [Mum] *is a bit of a lazy lump.*" However, this could have been the researcher's interpretation as this health visitor was generally quite expressive in her use of language. Another health visitor reported that she and the GP, who one mother was "*driving ... absolutely mad*" because of her constant demands, seemed to recognise she was being judgmental when she said "*we call it – I mean this is very naughty ... but it's called the* [mother's surname] *syndrome, as long as it's not catching we're alright* [laughs]". This latter example appeared to illustrate a coping mechanism on the professional's part as this health visitor was clearly aware of the potential for this mother to develop psychiatric problems and had been very supportive to this woman and her husband.

Health visitor 3.71 also described the stereotypical judgements which practitioners can make about certain community areas and the assumptions that automatically follow:

> *I think often places like* [place] *are judged, they're prejudged, often seen as like, "oh god is it awful to work there? Are things really bad? The parents are awful and ..." there's that side, and also, we've had people sort of helping out from different areas, like the* [place] *area, and they're giving advice at clinics, and people sometimes come back to you and say, "oh the Health Visitor there, she told me to do this, that and the other and I can't afford to, why should I be doing that?", and it's about sort of assessing what's suitable to say.* (HV 3.71:373-375)

These difficulties were particularly apparent when bank staff unfamiliar with the needs of a local community come to work in an area.

8.2.6 All clients can potentially have unmet needs

There was a consensus of opinion amongst the health visitors that any client or family could potentially have unmet health and/or social needs. Health visiting starts from the premise that all families can potentially experience health needs and as such have a need for health visiting services, increased support and/or referral for other services.

This fact is highlighted by HV 2.06:

> *... I'm going into families which would be perceived as normal families, with two parent families, 2.4 children and all the rest of it and the needs are just as great if not greater, 'cause it's just really looking at what somebody perceives as a need individually and how and just as some people are quite happy, they can get by with income support, they can get by ... and that to them is okay, that's fine, ... another family can, you know, finances aren't a problem, but you've got husbands that are sort of working all these long hours and not recognising the needs and lots of the women who've worked in well paid jobs and everything, and suddenly they're at home all day with babies and ... can't quite get to grips with it and the depression sets in ...*
>
> (HV 2:06:63-64)

The demands of parenting and the difficulties experienced by new parents are highlighted further by the following client when she said:

> *I think without friends I'd go round the bend. I never realised what motherhood was going to be like. I thought that the house would be immaculate ... But it's nothing like I thought it was going to be. All I seem to do is look after the children and me ... I now understand why on telly you see people campaigning for mothers to be paid because it's just unbelievable – really hard work. ... We go to mums and toddlers normally on a Monday morning they run one sort of locally in the church, which is brilliant but getting out with the two of them is like a military operation.*
>
> (C 2.77.2:77-85)

While the challenges of parenting are apparently recognised at Government policy level (Home Office, 1998), a theme tentatively running through the health visitor interviews was that Trust management does not wish (or cannot afford) to acknowledge that families who are apparently 'normal' may also have needs. ('Normal' in the sense that the family does not come from an 'obviously' deprived background and has no obvious child protection risk factors). It almost seems that there is an expectation that these families should not have needs and if they do, that they should sort them out themselves, with little or no professional support. This view is reinforced by a presence in all study sites of limited core programmes, which impede preventive work and an emphasis on extra health visiting, only for so-called 'problem families'. There is also a rather unrealistic expectation that 'experienced'

parents, unlike first time parents will be able to draw on their experiences and cope with their children's demands. However the difficulties faced by some of the parents participating in the study highlights the need for continued support to any family in need. As one client and her mother described:

C: *This is my sixth child and I've, I'm still like a nervous mother all over again. It's even worse as you get older. The more children you have it's not as easy, it's not easy as people say it is. It's not though, is it mum? It gets harder.*

GM: *No you see more things you know than what you did when you were younger.*

C: *Yeah. It's harder as you get older and there's more children you have, it is harder, there's more worry involved in it. ... It's a lot of rot when people turn round and say, "oh you've had children you'll be alright, you know what to do", no you don't!* (C 3.53.4:288-295)

Indeed previous research has suggested that health visitors may not fully recognise or possibly underestimate the needs of parents with two or more children (Weatherley, 1988; Plastow, 2000).

8.2.7 Prioritisation

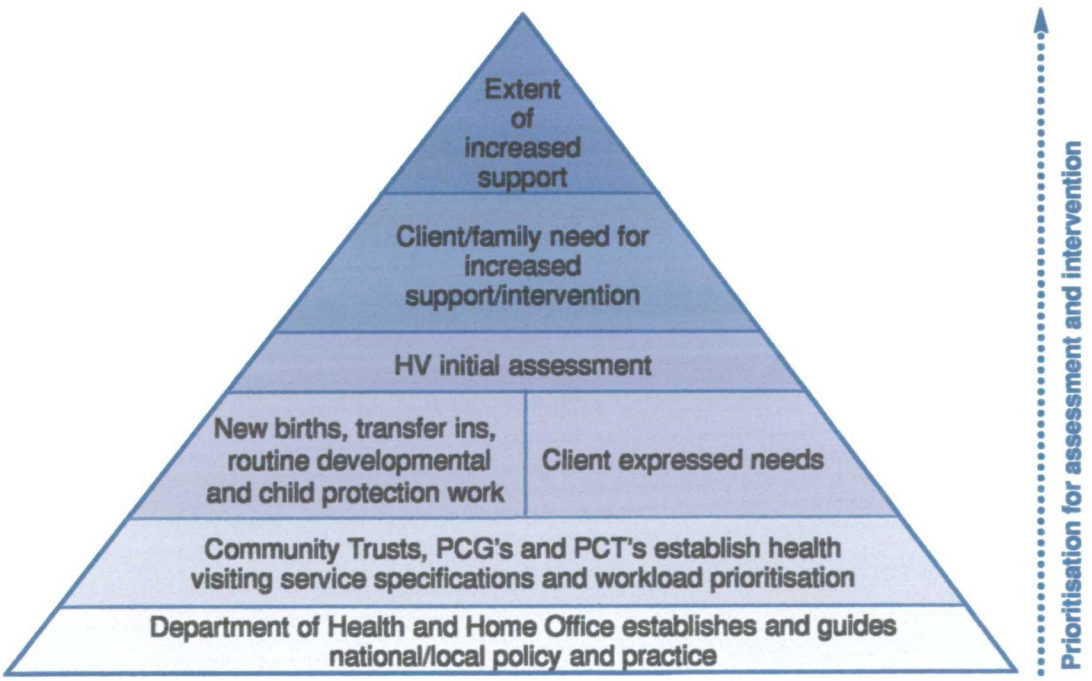
Prioritisation in terms of assessment appears to take place at several levels (See Figure 8.2). Firstly, in terms of the wider social policy arena, Department of Health policy initially guides and determines local Trust agendas and the focus of health visiting work. This brief is likely to intensify with an increasing emphasis on the implementation of National Service Frameworks. Community Trust service specifications and requirements for health visiting work then determine the client groups whose needs are to be addressed by the health visiting service. As previously outlined in Chapter 6, across all three study sites such service specifications result in health visitors prioritising families whose needs are to be assessed. This prioritisation appears to encompass two elements. Firstly service specifications require health visitors to give high priority for assessment to new birth visits, transfer in visits and developmental checks – as one health visitor described "*the routine stuff*" (HV 3.71:16) as well as child protection work. At this level, prioritisation for assessment reflects a general response to service requirements rather than client need:

> *The things that we have to do because of policies are you know the new birth visits, the transfers in, they have to be a priority, and the developmental checks. They have to be a priority to get them in at the right time ...*
> (HV 2.06:207)

Health visitors 1.82 and 1.25 described how as well as new birth visits and families transferring in to the area, "*the high intervention families*" needing increased support have to take a priority on their caseloads. It was interesting to note that two health visitors (HV 2.17 and HV 2.38) in Site B, referred to families who needed to be assessed, such as families transferring into an area as "*high priority*", prior to undertaking a visit. In this sense they are a priority for initial contact, however, following the initial contact they may not be a family who would be regarded as a priority for increased health visiting support.

A second priority for health visitor assessment are those clients requesting increased support, with prioritisation taking place as a response to client expressed need. A recurrent view was that any client requesting help would take priority for assessment. In the following extract HV 1.39 describes how she would prioritise any client asking for assistance and if necessary would cancel visits to try and see the client the same day:

Figure 8.2: Levels of prioritisation for needs assessment



I mean if mum called me and said she needed me to go that day then I would look at my diary to see what else I had booked in and if it was things I felt I could cancel – visits I felt I could cancel I would do so. (HV 1.39:698)

The fact that health visitors give priority for assessment to clients expressing needs and/or asking for help, also appeared to be supported by several of the clients in the study (See Table 8.4 for evidence of health visitors' responding to client requests for contact). Thirdly, prioritisation takes place once an assessment has been made in the fact that health visitors prioritise which families they are going to offer extra support to. Thus the outcome of the health visitor assessment leads to prioritisation of which clients/families will be offered extra support, as well as the nature and extent of that support. However, there was general agreement amongst the majority of health visitors that demand for the service often outstrips available resources and lack of time was a major factor in determining priorities of need. Several clients also recognised the increasing demands being placed on the health visiting service.

Table 8.4: Health visitor response to client request for contact

Client	Client encouraged by HV to make contact	HV responds to a client request for a contact	Client would contact HV with needs
1.15.1	Yes	HV sees at home or clinic or accompanies to hosp' appts	Yes - phones HV for help
1.15.2	Observed	Visits when client rings with a concern/chases up referrals	Yes contacts HV and 24 hour service
1.15.3			
1.15.4	Yes and observed	HV responds to any needs client raises in clinic	Yes speaks to HV in clinic
1.25.1	Client not interviewed	Client not interviewed	Client not interviewed
1.25.2		Yes	Yes phones HV
1.25.3	Observed	Yes	Yes phones HV
1.25.4		Client interview not taped	
1.39.1	Yes	Rings HV in tears & HV visits took to hosp' when in labour	
1.39.2	Yes and to contact 24 hr service	Yes	Yes would contact HV or 24 hr service
1.39.3	Yes	HV always returns client's call if not there	Yes contacts HV & night on-call service
1.39.4	Yes	HV will visit same day client calls her*	Yes does phone HV & on-call service
1.39.5		Yes HV goes round immediately*	Yes often phones HV
1.70.1	Yes		
1.70.2	Observed	Yes HV pushed for social services to visit family	
1.70.3			
1.70.4	Observed		
1.82.1	Client not interviewed	Client not interviewed	Client not interviewed
1.82.2		Yes HV calls client if not in office, will go round ASAP*	Yes

Table 8.4 (continued): Health visitor response to client request for contact

Client	Client encouraged by HV to make contact	HV responds to a client request for a contact	Client would contact HV with needs
1.82.3	Yes	Yes makes appt. to see client. Pushes forward a referral	Yes does phone for help/advice
1.82.4	Observed	Yes will visit when client calls her	Yes does phone HV or accesses in clinic
2.06.1	Yes and observed	Visited daily outside her area - when client desperate	Yes phones HV with any problems
2.06.2	Observed	Yes	Yes has phoned HV re child care issues
2.06.3	Yes	Yes rings client later same day if not in office	Yes knows she can contact HV anytime
2.06.4	Yes and observed	Yes	Yes for advice re children but not self
2.20.1		Clients walk in see HV in surgery, took to hosp' in labour	Yes phones or goes to see her in clinic
2.20.2			Yes does, but not always happy with advice
2.20.3		Yes came out to see client when she called her	Yes
2.20.4		Gets back ASAP to messages report father & mother	Both parents have contacted/been to see HV
2.38.1	Yes	Yes she visits client at home	Yes HV there when mum needs her
2.38.2	Yes		Yes
2.38.3			Yes
2.38.4	Yes	Responded to client's message and came out same day	Yes and to contact 24 hour service too
2.77.1			Yes
2.77.2	Yes		Yes she does phone HV
2.77.3		HV comes out if mum asks . her to, Sat am clinic set up	Yes will phone her or go to see her
2.91.1		HV will go round if needed	Yes will phone or call and see her
2.91.2			Yes would call or go to see HV
2.91.3		Checked on family when mum in hosp' gets prescriptions	Yes does phone HV
2.91.4		Yes had visited twice in a day	Yes does phone HV
3.07.1	Observed		Yes
3.07.2			
3.07.3	Observed		
3.07.4	Observed	Yes	Yes does phone HV
3.49.1			Yes
3.49.2	Yes	Yes	Yes rings HV will go to clinic
3.49.3			Yes does phone HV
3.49.4	Observed - Client not interviewed	Client not interviewed	Client not interviewed
3.53.1	Yes	Yes HV will come out to client	Yes
3.53.2	Observed - Yes HV home phone no. given	Yes HV will come out same day or next morning	Yes does phone HV
3.53.3		Comes out to client or sees in clinic, brought her nappies	"A helping hand at the end of the phone"
3.53.4	Observed	HV will come out to see her if client needs her to	Yes will contact HV
3.71.1			Would go straight to HV with any concerns
3.71.2		Yes comes out if client asks	Yes phones HV
3.71.3	Observed	*	Yes would contact HV
3.71.4	Observed	HV came out to see client today for sleep problems.*	Yes

* Accompanied visit - in response to client request for contact.

8.3 Summary

This chapter has outlined the seven fundamental principles that emerged through data analysis, these features appear central to health visiting assessment and continually appeared within the data. These characteristics are integral to, and provide the basis upon which health visitors' assessments are conducted and professional judgement is formed. The assessment principles and their attributes reflect the basic principles of health visiting assessment practice which exist despite the constraints and realities of the practice context and can be differentiated from the activity centred methods of the assessment process. Some principles, such as the on-going nature of health visiting assessment, its general complexity and the influence of personal values and experiences are already well documented in the literature. However, other elements, such as the clear evidence of prioritisation and the potential for any client/family to have unmet health or social needs are more new. In attempting to unravel some of the complexity of health visiting assessment processes, this chapter has offered a visual conceptualisation of the seven assessment principles. Chapter 9 will move on to explore in more detail the intricacies of health visiting assessment processes.

Chapter 9

The Identification and Assessment of Family Health Need – Health Visiting Assessment Processes Under Scrutiny

9.1 Introduction

This chapter will present a detailed analysis of health visiting assessment processes. It will attempt to explicate the various elements associated with the processes of identifying and assessing family health needs. Chapter 8 has outlined the basic principles underpinning health visitors' assessment practices. This chapter will explore the seven key elements including their sub-categories that constitute the activity centred methods of health visiting assessment. In doing so it will attempt to unravel some of the complexity of these process elements. Health visitors described the assessment of family health need as an information gathering activity, with health visitors' co-ordinating data from a variety of sources in order to assess family health needs and formulate professional judgements. The analysis suggests that the health visiting assessment process is a complex interactive activity, with many processes interlinking and occurring simultaneously. Furthermore because of the individuality of health visitors each would place a slightly different emphasis on these various factors in relation to unique family situations.

The chapter begins by illustrating the diverse range of interpersonal skills employed by health visitors when conducting their professional assessments. It will then move on to explore the various sources of knowledge which health visitors draw on when making family assessments, before examining the intricacies of health visiting assessment processes. Health visitors adopt several strategies and process actions to aid their assessments that will be described in the chapter. A number of facilitative factors appear to ease the process of assessment and judgement formation, while conversely there are

negative or inhibitory actions that do not legitimate client need. A key finding of the analysis was the integration of some health visitor intervention activities with assessment processes. Thus the analysis indicates that assessment is significantly intertwined with many other factors which are integral to the assessment process.

9.2 Health visiting assessment processes

This chapter will attempt to unravel some of the complexity of health visitor assessment processes. Figure 9.1 illustrates the elements of assessment, which are extremely labyrinthine and involve health visitors adopting a range of skills. Seven key factors constituting assessment processes were identified :

- interpersonal skills
- potential knowledge base in use
- processing knowledge to aid the assessment
- facilitating factors
- strategies adopted to aid the assessment
- assessment as intervention
- inhibitory factors.

It is essential to be clear that these factors are interlinking and each health visitor places varied emphasis on them in different client contexts. The elements are illustrated in relation to the assessment principles described in Chapter 8.

9.3 Interpersonal skills

The findings suggest that health visitors employ a diverse and complex range of advanced interpersonal skills when gathering data and conducting their professional assessments. The use of interpersonal skills for assessment purposes could be an entire study in its own right, but the key elements are summarised in Figure 9.2. Although not all communication elements are used at each client encounter, many occur simultaneously, with health visitors attempting to take in the whole situation, by observing clients in context, as well as tuning in to verbal cues. As one health visitor describes: "*I'm absorbing the impact of the whole and not just the one to one interaction that's going on*" (HV 1.82.2:295).

Figure 9.1: Health visiting assessment process

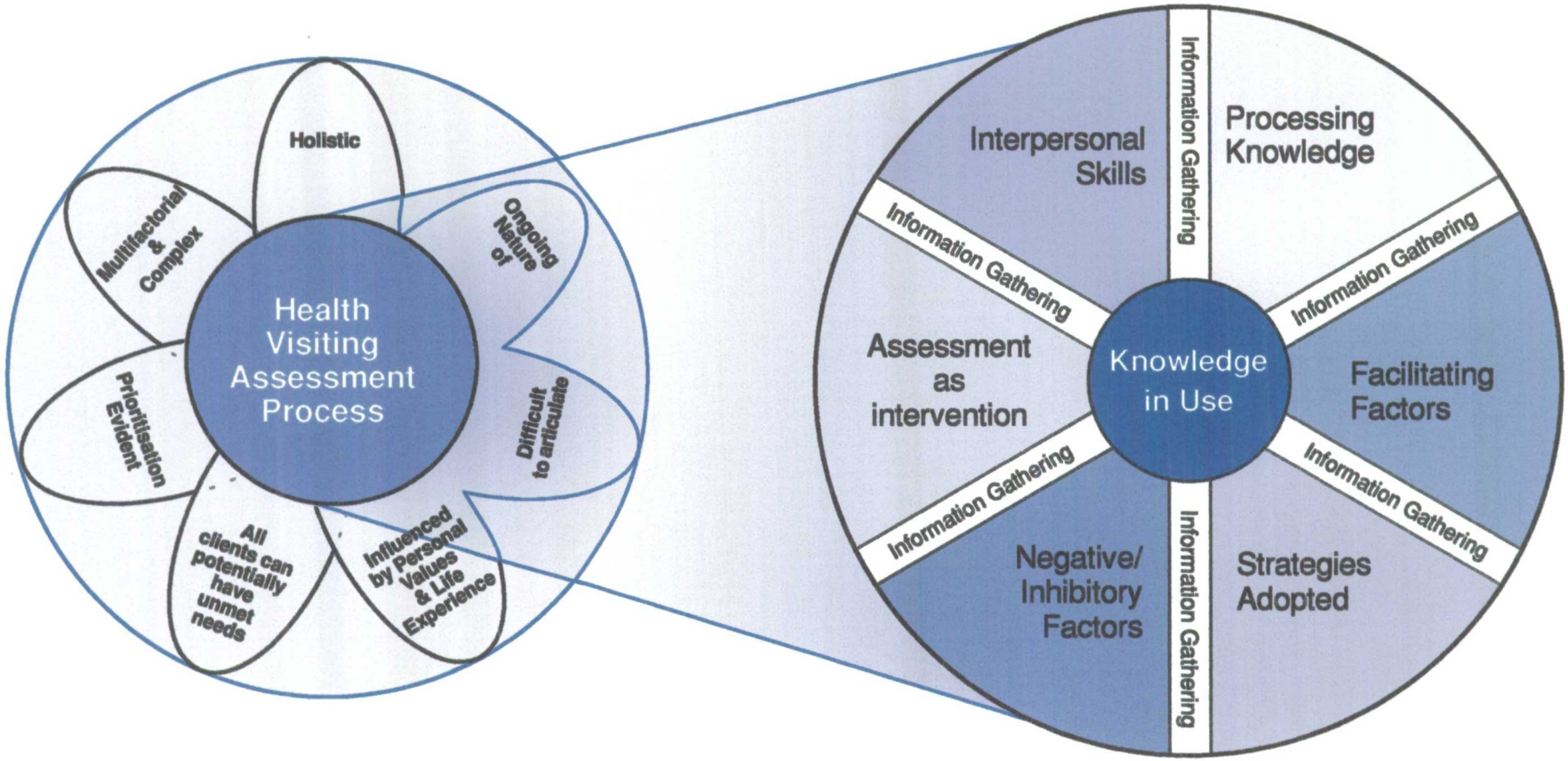
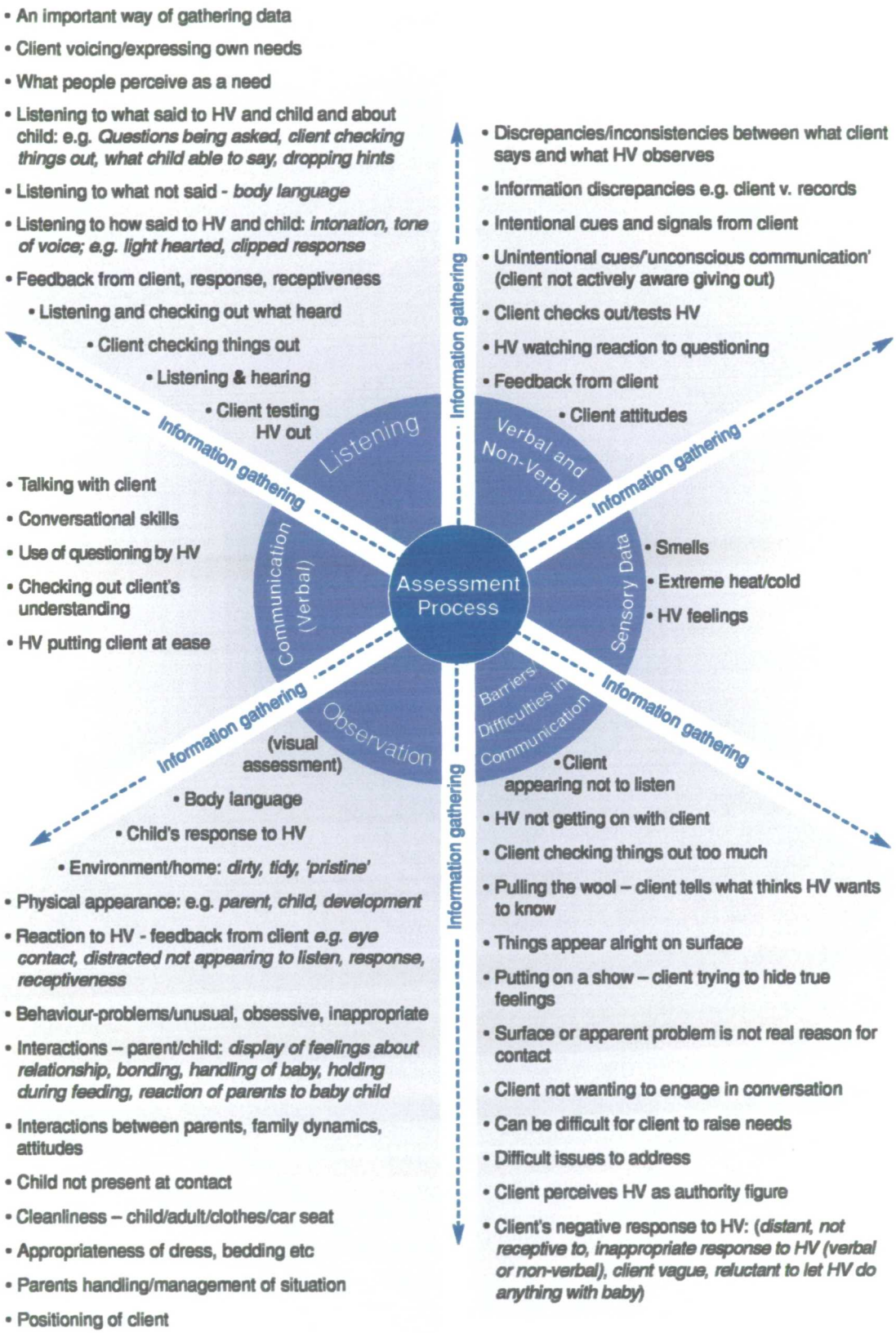


Figure 9.2: Basic interpersonal assessment skills



The data were littered with examples of health visitors drawing on a range of communication strategies to fulfill their professional assessments. One health visitor said:

> *... it's the scene, it's what they tell you, it's how they tell you, it's what you see, it's what you know about them from previous visits and it's how they respond to us being there.* (HV 3.49:86-87)

She went on to explain "*how they tell you things*" as:

> *Well either cheerfully or with eye contact, or flat tone or voice, or willing to talk or having to be encouraged ...* (HV 3.49:89)

For example, when assessing how parents are coping with the arrival of a new baby, health visitors commonly described observing how parents handle and talk to their new baby, particularly observing body language and being sensitive to "*the hidden cues that people give*" (HV 2.06:102). Health visitors describe how pulling together contradictory information may enable them to make a judgement that a mother is depressed or not coping. Sensitive discussion with clients and active listening were strong themes within the data as health visitors attempted to understand and assess client need. As Chalmers (1993) has previously found health visitors use their interpersonal skills to pick up client cues and determine that a need exists.

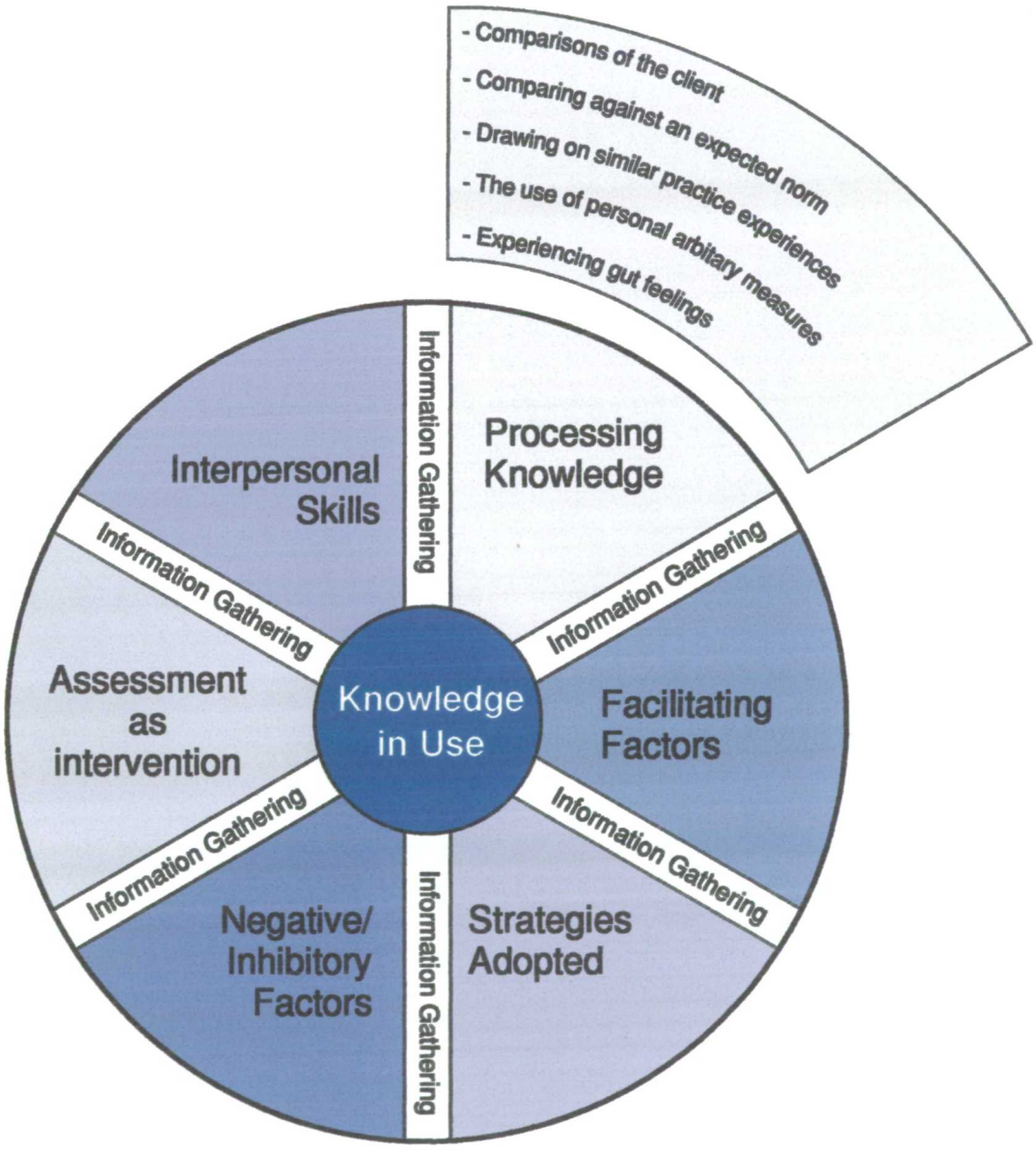
9.4 Knowledge in use

The knowledge apparently in use during observed visits is summarised in Appendix 9.1. This data is presented only to give a flavour of the range of knowledge health visitors' appeared to apply in practice and is not intended as an exhaustive or definitive statement. Indeed, during post-visit interviews health visitors sometimes reported drawing on knowledge that had not necessarily been evident to the observer. At a very simplistic level, it was possible to determine for example, health visitors' knowledge of infant feeding, when health visitors discussed breast feeding or weaning with clients. Sometimes a visit would reveal the health visitor drawing on the same type knowledge at different points in the visit. For example, the use of knowledge about child development is evident when a health visitor explains an 18/12 developmental assessment to a parent and then later when she offers the client anticipatory guidance on home safety.

9.5 Processing knowledge to aid assessment

It became evident that health visitors actively process knowledge to aid professional assessment and judgement formation. Processing knowledge takes place in a number of ways (See Figure 9.3), with health visitors either making comparisons against an expected or 'learned' norm or comparing a client's current appearance, behaviour or actions with those previously witnessed. Other ways health visitors' process data include drawing on knowledge from previous experiences, applying personal arbitrary measures and through the experience of gut feelings.

Figure 9.3: Processing knowledge to aid assessment



9.5.1 Comparisons of the client

Comparative knowledge of the client was used when health visitors make an assessment of a client's current demeanour, appearance, behaviour, action or situation and compare this with information previously gathered and their existing knowledge of the client. As HV 3.49:87 states "*it's what you know about them from previous visits*". This comparative process was described by a small number of practitioners during the initial interviews but became strikingly evident as a strategy that all health visitors talked about during the post-visit interviews. This health visitor describes her observations of a young woman, whose partner, a heroin addict, arrived home with his face slashed by local drug dealers who were pursuing him for money. She makes a comparative assessment based on her existing knowledge of the client:

> *... she was definitely less stressed than what she was the week before when I'd seen her ... the week before she was unable to think clearly about the situation, she was very tearful, she was jumping from one topic to another, that type of thing, so she really couldn't clearly look at the situation that she was in at that time. Now today she still talked non-stop and it's ever so difficult to keep her on line ... but she was able to perhaps think – to be able to talk more clearly, to be able to reflect back on the situation, to admit that she's still not, she doesn't know how she feels about him and whether the situation will go on or not, but that she was strong enough to say "go", and to recognise now, even – you know a week later that the risk was there whereas a lot of people may well have chosen to ignore it or to think you know "have him back', but no, she's not going to do that.* (HV 2.06.1:129-131)

Health visitors often used a range of descriptive terms (adverbs and adjectives) to initially illustrate their comparative assessment, with an implicit assumption that the interviewer would understand their meaning e.g. "[2 years 9/12 old] *certainly looked a lot better*" (HV 3.07.4:126). Some practitioners seemed to make these comparisons automatically with little recognition that they were actually doing this. In such cases it was only through probing that the health visitors offered greater detail about the comparisons they were making. For example, when probed HV 3.07.4 said:

> *Well his colour was better, I mean – he's quite pale anyway, but certainly his colour looked better and he was playing and he got to be a bit of a nuisance really – as most two and a half year olds do ... you know considering what he was like before, it's a vast improvement ...* (HV 3.07.4:142)

Health visitors used comparative knowledge to determine whether their interventions were effective, to explore if clients had made progress or had taken up their advice. They would make comparisons by referring back to issues discussed at previous contacts. The ability to elicit and use comparative knowledge was evident in many visits and appears to be a central feature of assessment practice. This capacity to make comparisons was linked to the health visitor having some previous knowledge of the family and in fact many commented how "*it's easier to judge*" (HV 1.39:177) if they have met a client previously. If this prior knowledge does not exist then the potential to make comparisons becomes non-existent because the comparative element is absent. One practitioner described how she initially failed to identify an anorexic mother displaying obsessive behaviour, because this comparative element was missing:

> *... it's not something I picked up the first time you know, it's something you get that from going back and seeing what is really going on.* (HV 1.82:228)

9.5.2 Comparing against an expected norm

Health visitors also process knowledge by making comparisons against an expected or 'learned' norm. This type of knowledge appears to equate to theoretical or propositional knowledge as described in Chapter 2. Implicit in being able to make such comparisons is having the desired level of knowledge in the first place. This view of the norm may be refined and developed through a health visitor's professional experience of working with other clients. Drawing on their knowledge of the 'expected norm' health visitors were frequently observed to reassure parents about their child's developmental progress or behaviour.

In the following example HV 1.70 describes how she drew on her knowledge and experience of mothers and babies to discover a four-month-old in need of protection. She had initially acted on her intuitive feelings and sense of unease about the family:

> *they were bothering me because there was a point where social services had gone in because they had a complaint that the child had a bruise and when the social services went in they said that the bruise was consistent with what mother explained but I did not feel comfortable with the explanation and it kept niggling at me ...* (HV 1.70:258-259)

So this health visitor called on the family unannounced and when she arrived, mum came to the door and told her that the baby had been crying for a long time and she did not know what to do. The health visitor initially tried to settle the baby and offered a bottle of formula but the baby wouldn't suck and continued to cry. This raised concerns for the health visitor as the baby's behaviour deviated from her expected view of the norm. Furthermore the mother's behaviour was also at odds with how she would have expected her to behave:

> ... *what struck me when I was there was, most mothers if you take the baby for them and you can't quieten the baby, most mother's say "let me have a try." A good three quarters of an hour and mum didn't say once "let me have a try to settle down the baby." It continued to cry ... again that increased my unease* ... (HV 1.70:272)

She went on to explain:

> *when the baby didn't settle my anxiety increased again because, let's face it, if you cuddle a baby long enough and chat to a baby long enough, generally they stop for a while but this child didn't, not only that and this is where I think some of it comes with experience. If you look at children they can tell you things with their eyes and this child said to me – I'm terrified* [HV's name]. *Honestly, that's the only way I can describe it, the child's eyes were terrified.* (HV 1.70:290-291)

In making sense of the complexity of this situation, drawing on her knowledge of expected norms, linked with an intuitive awareness and sense of unease this health visitor eventually contacted the GP who suggested that she should get a paediatric opinion. The health visitor then arranged for the baby to be seen in hospital and on examination the baby was found to have fractured ribs and a fractured tibia. Social services became involved and the baby was placed in the grandparents' care. This situation illustrates how crucial it was for the health visitor to use her knowledge of expected norms and respond to her intuitive concerns about the family in protecting this young baby.

9.5.3 Drawing on similar practice experiences

Some health visitors actively drew on their knowledge of similar practice experiences when making family assessments. In such cases similarities are drawn between aspects of the current situation and previous family cases of which the health visitor has had direct experience and has some memory of the unique aspects of the previous family. Similarities are drawn when aspects of past and present cases seem commensurate. For example, a health visitor described how her knowledge of a recent cot death raised her own awareness about addressing SIDS preventative measures with parents, by discussing cot death risk factors:

> *I think an event can actually I think reinforce ... how you actually give that information and the importance of it really.* (HV 2.06:88)

This process of drawing on known practice experiences appears to differ from the more general experiential knowledge which health visitors use when making assessments, based on their knowledge base accumulated from life and practice experiences, the origins of which is largely imprecise.

9.5.4 The use of personal arbitrary measures

When processing data three health visitors described applying their own personal arbitrary measures when making an assessment. HV 3.71 describes how when she is faced with a complicated situation she will sometimes ask a client to describe "*in a sentence what the three worst things are at the moment*" (O 3.71.1:61). She adopts this strategy to assess whether the client is able to sift out and prioritise thought processes to find out how chaotic things are. Health visitor 2.77 states that she uses whether people smile or laugh at her jokes as a measure of whether or not they are depressed, while HV 1.39 described routinely inviting new mothers to attend clinic as a measure of their coping abilities. She feels it is essential for them to get out and make contact with others to make it easier for them to seek help if they do feel low. This health visitor also described using another arbitrary measure to explore parents' feelings regarding a new baby's arrival. She expects parents to feel like 'the baby has always been there' and uses this as a measure of 'normal' feelings.

9.5.5 Experiencing gut feelings

Discussions during the initial interviews indicated that all the health visitors sometimes experience gut feelings when conducting family health needs assessments as previous research has found (Appleton, 1995; Goding, 1997; Ling and Luker, 2000). Although the 'feeling' experience did vary between practitioners. The health visitors also indicated that if they experienced a gut feeling (sometimes referred to as a 'feeling', 'sixth sense', 'intuition', 'gut instinct/reaction' or a 'hunch') this would influence their professional assessment (See Table 9.1). Some believed that intuition is linked to personal and professional experience, values and knowledge gained through training and practice.

Table 9.1: Health visitors' descriptions of gut feelings

	Gut feeling	Instinct/ Gut instinct	A feeling/ Feelings	Vibes	Intuition	Gut reaction	Hunch
SITE A							
1.15	1.15. First 1.15.3			1.15. First			
1.25	1.25. First 1.25.1 1.25.3	1.25.3	1.25.3				
1.39	1.39.3		1.39. First	1.39.1			
1.70	1.70.2 1.70. First				1.70.First		
1.82	1.82. First 1.82.2 1.82.4		1.82.3		1.82.First 1.82.3 1.82.4	1.82.3	
SITE B							
2.06	2.06.First 2.06.1 2.06.2 2.06.4			2.06.4			
2.20	2.20.First						
2.38	2.38.First			2.38.2 2.38.3 2.38.4	2.38.4		
2.77	2.77.First 2.77.1 2.77.2 2.77.3	2.77.First					
2.91	2.91.First						
SITE C							
3.07	3.07.First	3.07.2		3.07.First		3.07.First	
3.49	3.49.1 3.49.4	3.49.1 3.49.3			3.49.First 3.49.1 3.49.3 3.49.4		3.49.First
3.53			3.53.First	3.53.First			
3.71	3.71.1 3.71.3			3.71.2 3.71.3	3.71.First 3.71.4	3.71.4	
3.89		3.89.First		3.89.First			

First = Initial Health Visitor Interview

One health visitor regarded gut feeling as being "*based on knowledge which is obviously internalised*" (HV 3.71:55), she felt that it wasn't "*just intuition on its own, it's an awful lot more...*" (HV 3.71:57). This suggestion that an intuitive feeling is a response to a combination of factors was a theme that became more pronounced as health visitors attempted to articulate the 'gut feeling experience'.

While the majority of health visitors regarded intuitive feelings as a response to external cues, five practitioners suggested that the feeling equated to more than this. In essence their view appeared similar to Benner and Tanner's (1987:27) description of intuitive judgement and a "*sense of salience*". These practitioners described intuitive feelings as a synthesis of three elements: a response to a complex range of external cues gathered through the senses, a feeling of personal unease and a sense that things are not quite right. Generally health visitors were able to link their 'gut feeling' with an external trigger, even if this meant experiencing the feeling and then searching out objective information to give it credence. Ling and Luker (2000:575) suggest "*the infusion of more concrete and explicit categories* [of knowledge] *could be seen as lending an aura of respectability to the more abstract and implicit category of intuitive awareness.*" They found health visitors relying on intuition only when it was substantiated by more tangible information.

The above description of intuitive feelings seems to link to Schön's (1983, 1987) use of the term 'reflection-in-action' combining professional artistry and intuition. Schön (1983) describes 'reflection-in-action' as the thinking that a professional undertakes concurrently with the acting at the time of action. Professional artistry is "*the intuitive knowing in practice by which practitioners make sense of practice phenomena to inform professional judgements and determine strategies in practice*" (Twinn, 1989:54). Schön (1987:13) describes it as the competence by which practitioners manage the "*indeterminate zones of practice.*"

A recurrent theme within the initial interviews was that if a health visitor experienced a gut feeling this was likened to a sense of something not being 'quite right', which is a consistent finding in the literature (Kenny, 1994; King and Appleton, 1997, Ling

and Luker, 2000). Gut feelings were often initially inexplicable, but to experience one tended to leave the health visitor with a sense of unease and an impression of not getting to the bottom of things. Health visitors also suggested gut feelings alerted them to be more receptive to client cues:

> *... I think it just puts you on your guard more and makes you more receptive to any thing that might be said by the family ...* (HV 1.39:631)

In the majority of cases when health visitors experience a gut feeling it is a trigger for further assessment. Only one practitioner was critical of this view, stating that she did not feel comfortable about checking out a feeling unless she also had another reason to do so. Yet for most health visitors, a gut feeling would lead them to take further action, whether this be further assessment, raising issues with a client or reflecting on the 'feeling experience'. Confronting issues with clients was not always easy, but one health visitor stressed the importance of checking out these "*panicky*" feelings. When this health visitor was asked to visit a client to talk about her son's sleep problems her gut feeling enabled her to pick up that the mother was actually concerned that her child was being sexually abused:

> *... I cannot now for the life of me remember what it was she said that made me then say to her, "are your real concerns around what happens when your little boy goes to stay with your husband and the fact that you think that he may be sexually abusing* [name]*?" and she was so relieved that somebody had actually put it into words for her because she hadn't been able to do that and ... it was something to do with the way she phrased something that she said about it that made me think, you know, this mum's really worried about something other than the fact he doesn't sleep ... it stemmed from a gut feeling about something that she had said, so again it's something that was, you know, came through listening very carefully to what was actually being said and the way it was being said ...* (HV 1.82:257-270)

Acknowledging gut feelings

All health visitors acknowledged that it was important to take note of intuition, despite its apparent subjectivity and not being widely accepted as a valid criterion for assessment. Health visitors indicated that they value gut feelings highly and give them serious consideration:

> *I know that that's an unscientific way of working but I do think that that is something that is really important in health visiting ...* (HV 1.82:247)

Many health visitors regarded it as a safety net for their practice, leading to a certain level of vigilance despite its 'unscientific' nature. Although keen to acknowledge gut feelings, there was a general reluctance by the health visitors to record such feelings in their records. As Ling and Luker (2000) have described this raises an issue about the extent to which this type of knowledge is open to public scrutiny.

To experience a gut feeling increased a practitioner's state of alertness, undoubtedly because of the effects of the autonomic nervous system, three health visitors described it "*like 'panic'*" (HV 1.82:275). Health visitors were divided on whether they regarded intuition as a physical sensation or not. With some health visitors describing it "*like a little voice*" (HV 3.71.4:249), some were adamant it is "*not a physical feeling*" (HV 1.39:658), while others described a physical sensation:

> *It's just like butterflies in your tummy.* (HV 2.06.4:380)

While a minority of practitioners acknowledged that sometimes gut feelings can be wrong or don't materialise into anything concrete there was a widely held view that they are often correct or indicative of a problem. Adding a further dimension, three health visitors described how significant it was to their assessments if they did not experience a gut feeling or the feeling sensation was in some way different. HV (1.70.2:349) described how when visiting a single mother living in temporary accommodation with her five young children, despite the severe difficulties this mother was facing she combined her past experiences and drew on her feelings to conclude that this mother was not "*someone who would physically abuse her children.*" Here the health visitor made a judgement about the client's parenting abilities, which appeared similar to the 'use of discretion', described by Ling and Luker (2000). In such cases, gut feelings did not indicate something was potentially wrong but in contrast seemed to signify all was satisfactory.

Several health visitors found it quite difficult to explain the gut feeling experience, as everything occurs simultaneously and "*it's not something very tangible*"

(HV 1.15:224). One suggested that on analysis it probably wasn't a feeling but "*a collection of information*" (HV 1.39:669). A small number of health visitors suggested that intuitive feelings are likely to be based on fact and if they consider them carefully, can usually identify the factors that are raising their concerns. There was a suggestion from some that gut feeling may be an immediate response to a situation, while cognitive processes assimilate.

Appendix 9.2 illustrates health visitors' reports of gut feelings during the observed visits and their initial assessments of families. Despite health visitors' views about the apparent significance of gut feelings when conducting needs assessment, in practice they only described gut feelings entering into their initial family assessments on eight occasions. This may strengthen Lemmer et al's (1998) findings that health visitors have overestimated the impact of gut feelings in decision making. Furthermore on only 14 occasions did health visitors describe experiencing intuitive feelings during the accompanied visits and only HV 3.71 described a gut feeling experience at each visit. It was also interesting to find that a minority of practitioners encouraged clients to trust their intuitive feelings and this was particularly evident with HV 3.49.

9.6 Facilitating factors

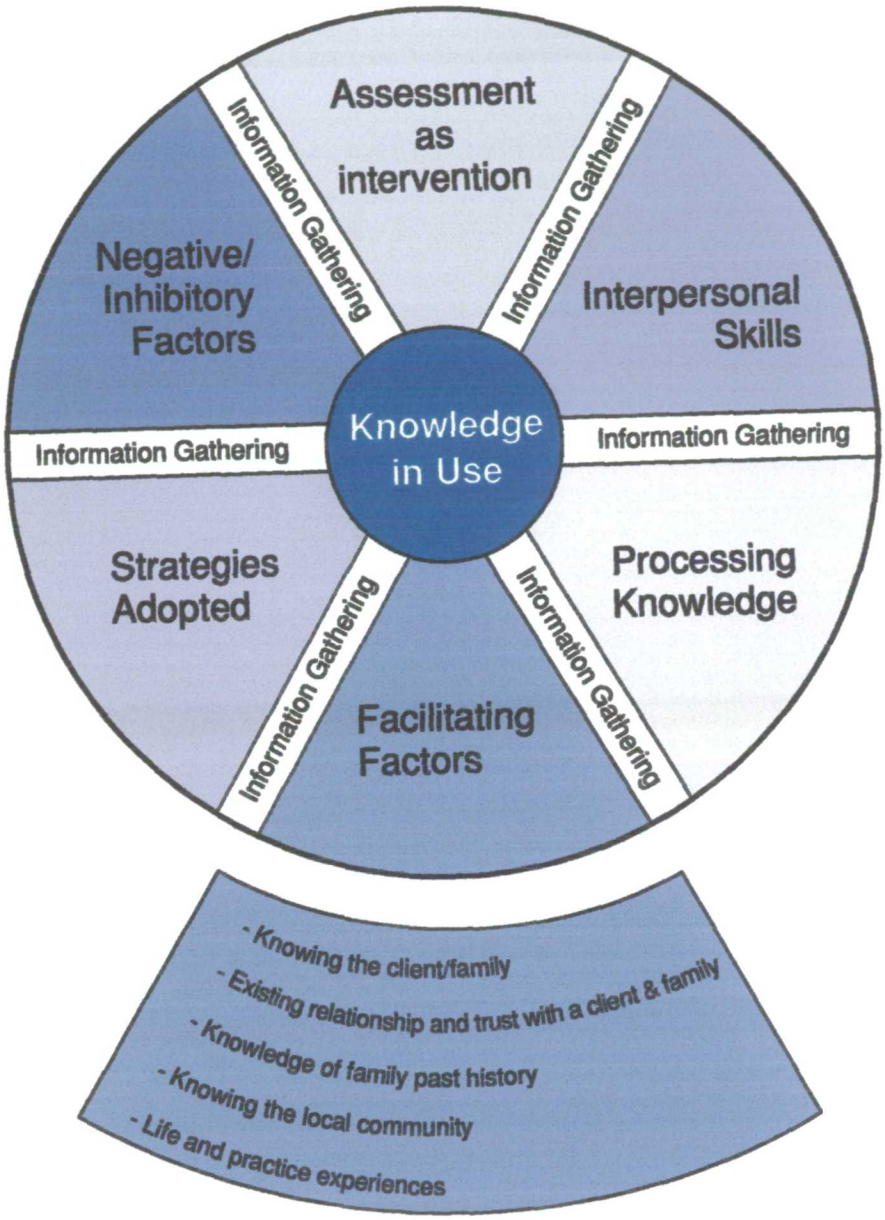
Data analysis indicated that there were a number of factors, some of which are part of a health visitor's 'knowledge base in use' which appeared to aid health visitors in their assessment of families, these have been termed 'facilitating factors' (See Figure 9.4). They include:

- Knowing the client/family
- Existing relationship and trust with the family.
- Knowledge of family past history
- Knowing the local community
- Life and practice experiences.

9.6.1 Knowing the client/family

It was a commonly held opinion that a health visitor needs to get to know families and the community in which she is working in order to make assessments and that this

Figure 9.4: Facilitating factors



level of knowledge can improve the accuracy of assessments. However, a small number of practitioners did point out that because of lack of time, "*we have to make* [and rely on] *an immediate assessment*" (HV 1.25:60) and as such all assessments have to be effective. A comparable concept, that of knowing the 'patient' has been well documented in the research literature and is regarded as an important dimension of needs assessment (Tanner et al, 1993; Radwin, 1995; Liaschenko, 1997; Watkins, 1998; Luker et al, 2000). Health visitors appeared to go to great lengths to elicit details about families and their situations, then use that knowledge in helping with specific issues.

The concept of 'knowing the client/family' was displayed in several ways in the study and consisted of a number of discrete elements. These included:

- Familiarity with the client and immediate family members
- Drawing on knowledge from a previous contact.
- Knowledge of client's extended family
- Knowledge of family's relationship with others in the local community.

Familiarity with clients and family members was exemplified when health visitors demonstrated their knowledge of family situations or their awareness of clients' perceptions of their needs. This knowledge drawn from a previous contact frequently gave the health visitor an opportunity to open up discussion around a particular health need. Health visitors often adopted this strategy at the beginning of visits to open discussion and to assess any progress made since the last contact. This approach was invariably executed through a questioning strategy. As Chalmers (1993) described this type of questioning was used to explore client health needs and gather data.

A classic example was observed when one health visitor opened up the conversation by referring to a holiday she had organized for the family through a local charity:

HV: *Right I think the first thing is how did you get on with your holiday?*

C: *Terrible ...*
(O 3.53.2:6-7)

This reference to the previous contact resulted in this mother raising several quite major health and social needs, including her concerns about her nieces being sexually abused.

Health visitors continually stressed the importance of getting to know the whole family and enabling people to feel comfortable with them. Some described how in doing this they carry a lot information about families in their heads without documenting this knowledge base anywhere. In some cases 'knowing the client/family' involved health visitors drawing on knowledge of the client's extended family. This seemed particularly evident in Site C, where extended families often lived in close proximity and the population was fairly static. Health visitor 3.71 describes how this influences her practice:

> *When I first started, that was something which I found quite difficult, because health visitors here were working four or five years and knew everybody, it tends to be quite a close-knit community, everyone's related to someone, so if you put one foot wrong in one family, that's it, you can't get in anyone else's door in that extended family at all.* (HV 3.71:367-368)

Health visitors' knowledge about the complexity of some family relationships and the sensitivities needed in dealing with these situations was often evident in these close-knit communities. For example, HV 2.20 drew on her knowledge of a young couple, Susan and Toby [1] and their extended family, as she was also the health visitor for Susan's mother's family. Susan and Toby were surrogate parents for her mother and this health visitor was able to draw on her background knowledge (of both families) to explore the couples earlier plans to become surrogate parents for his sister who has fertility problems.

In some situations knowledge of the extended family, enabled other family members to contact the health visitor with their own health concerns. Health visitors would also draw on their knowledge of client relationships with other families in the local community. In some cases this knowledge enabled health visitors to put clients in contact with others, particularly mothers living in isolated circumstances with little social support. Many clients valued this type of help.

9.6.2 Existing relationship and trust with a client and family

A central feature of getting to know a family is the building of a relationship between the client and professional. Many health visitors felt that it was ideal if they could get to know the family over a number of contacts and that clients value being able to access a professional they know. Chalmers and Luker (1991) have previously described the health visitor/client relationship as one that develops over a period of time; this is important for mutual trust to form. Building up client relationships appears a fundamental part of gathering knowledge and forming professional assessments. The findings suggest, as Luker et al. (2000) also found in a study of community nurses' beliefs about quality care, that assessment processes are facilitated

[1] Pseudonyms used

if the health visitor has built up a positive working relationship with the client/family and got to know them. This can also result in practitioners having greater job satisfaction (Luker et al, 2000).

Some practitioners stressed how important it is for clients to have the opportunity to build up a relationship with a single health visitor and develop trust in that person. The argument is that clients have to trust their health visitor in order to seek out and accept help in addressing needs. Many parents valued this aspect of relationship building:

> ... *we've always refused help or to have social workers round, we didn't think we needed it. You know we got, we get the support off and the advice we need from* [HV], *we don't need another source really. You know she provides us with all the help and support that we need you know and it took us a long time to build up that trust with* [HV] ... . *The trust is very important. You've got to have trust to make friendships because otherwise it just don't work* ... (C 2.20.4:470-473)

A desire from clients for continuity of care was also found to be a significant feature and enhances Luker et al's (2000) earlier findings, by adding the client perspective. Many clients wanted continuity from the same health visitor particularly those who find it difficult because of personal problems and/or low self-esteem to seek out help. Having a familiar professional can ease that process somewhat. This client stresses the importance of continuity from the same professional and recognises the comparative knowledge she possesses:

> ... [HV] *as soon as she walked through the door she saw* [child] *she knew that he'd grown, that he was looking well and I think it's very important for somebody who is supposed to be judging their health to be able to build up a picture from the past. It's all very well to have written notes and whatever but it does help if it's the same person.* (C 1.70.1:131)

Two clients had even decided not to change their GP because they had built up such a good rapport with their health visitors. One of these clients had changed GPs temporarily but became so disillusioned her GP advised her to return to her old practice.

9.6.3 Knowledge of family past history

When health visitors had some knowledge of the client or family's past history this appeared to facilitate assessments. Knowledge of past history was acquired in two ways. It could be drawn from either the health visitor's previous and direct experience with a family, through recall of events or could be indirectly elicited from records. Secondly, such knowledge could be gained directly from a client talking about their family past history.

Undoubtedly knowledge of a family's past history did influence professional assessments, particularly those cases where earlier events had had a negative impact on family members, or where parental violence or parenting difficulties posed a potential risk to the child(ren). Practitioners suggested that knowledge of such past history makes them more alert to potential problems. However, health visitors were clearly extremely aware of the dangers of being judgmental. Even in cases where there had been a pattern of previous concerns, many said that they would still want to make an assessment of the family over a longer period of time. Health visitors pointed out that second families with new partners can move on and as such past history may no longer be relevant to current assessments. Three health visitors also commented on the potential dangers of relying on past history gathered from records:

> *... It's easy to pick up notes and sort of read, I think you get drawn to the incidents, rather than to the status quo ...* HV (3.71:400)

This health visitor described how she would rather make a first assessment visit before reading the family notes to avoid making preconceived judgements because of the content of or the way notes are written.

The lasting impact of past events and negative labelling was evident in the case of one family, where an incident had occurred a few months prior to the health visitor taking over her caseload. Tentative concerns had been raised by nursery staff about physical abuse because of bruising to a 2½-year-old child's face, this had been investigated by social services and the nursery's concerns were unfounded. Yet despite this, when the health visitor took over the caseload a few months later, the nursery teacher drew

this incident to her attention, furthermore the family's records were labelled with a 'blue dot' highlighting the previous concerns. There appeared to be an art involved in holding knowledge about a family and not doing anything with it.

Knowledge of family past history impacted on health visitor assessments in different ways. Some practitioners described past history in terms of the client's own parenting history, whether or not as a child they had a good parental role model and how that impacts on their care of their own children. In some situations, clients decide to tell health visitors about aspects of their past life (both recent and past events) and this was witnessed during some visits. Therefore health visitors argued that it is important to consider past history "*if they're* [the client] *telling me, if they're talking about it and certainly if it bears relevance on what is actually happening now*" (HV 1.82:365). This health visitor described how when one client talked about her past history and obvious hatred of social services it gave her a cue to gather more information about the family's relationship with social services. She discovered that this mother was placed in a series of children's homes and was raped in one, at the age of nine. Subsequent investigation led her to discover that both school children were on the child protection register.

9.6.4 Knowing the local community

Health visitors' knowledge about the local community appears to have an impact on assessment processes. It includes having a good working knowledge of the local area, its resources and facilities, as well as individual local contacts. Health visitors continually described the importance of developing a good working knowledge of the community in order to make accurate assessments and initiate appropriate referrals to other agencies and services. There was an impression that this level of knowledge is built over a period of time and by profiling the community to address wider heath issues. Such knowledge also extends to knowing the levels of support different agencies can offer especially when resources are limited. Health visitors also stressed it is important to know the community so that health advice and interventions are made relevant to client needs and tailored to their personal situations.

9.6.5 Life and practice experiences

When conducting needs assessments, health visitors also appeared to draw on knowledge from life and practice experiences, the origins of which was often too vague for them to articulate. This appears to equate to experiential knowledge. This type of knowledge appears to be drawn from an amalgamation of practice and life experiences and practitioners are unlikely to relate this knowledge to a specific incident or event. One health visitor describes drawing on such knowledge:

> *... I suppose subconsciously you must draw on things you've learnt during previous experiences because inevitably you do end up using the similar skills for particular situations and similar referral agencies ...*
> (HV 1.15:277)

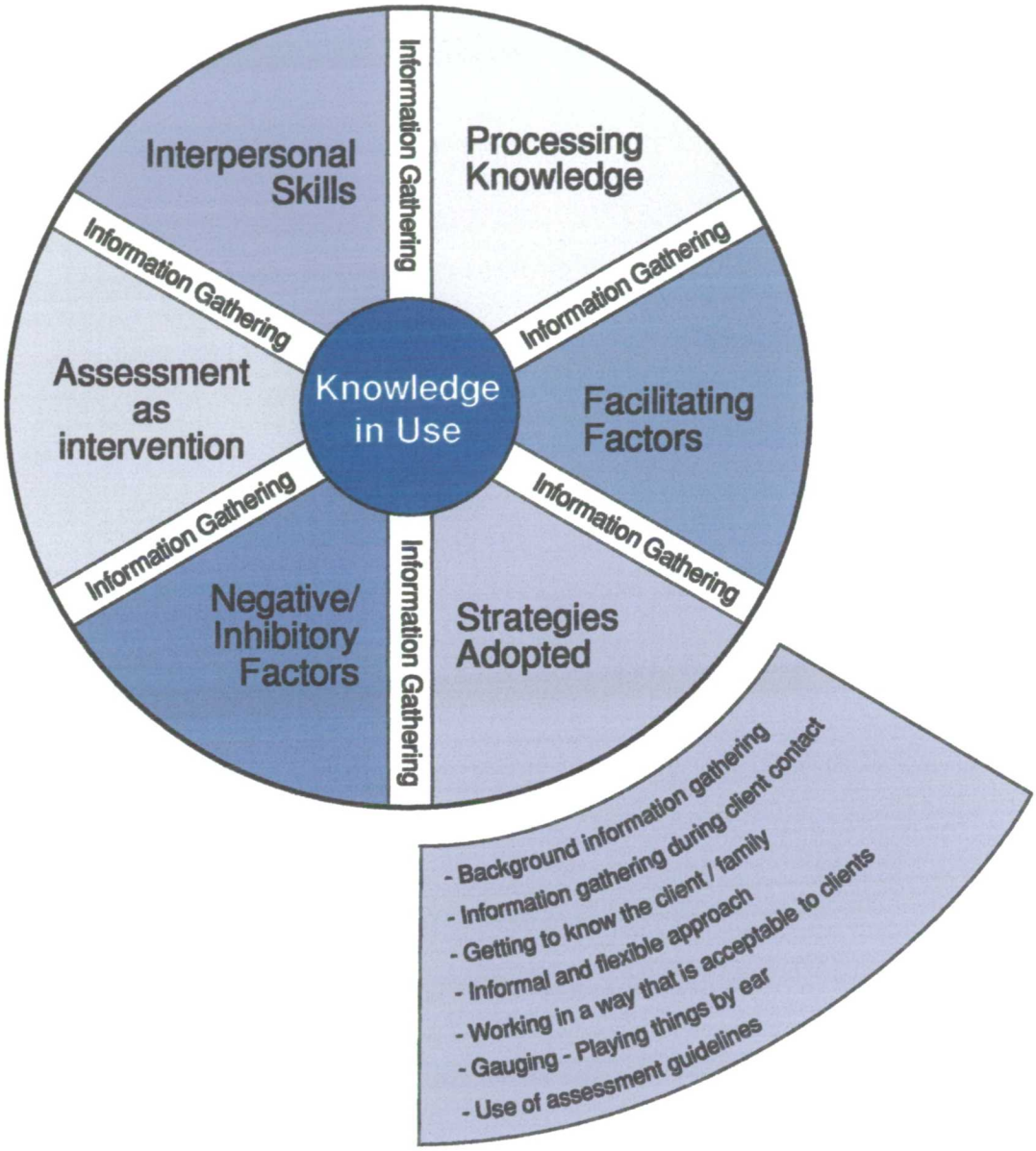
9.7 Strategies adopted to aid assessment

Health visitors adopted a number of strategies to aid their family assessments (Figure 9.5). These included overt strategies such as seeking background information about and from a client, while others appeared more subtle and relate to the health visitor's personality. By adopting an informal and flexible approach and 'playing things by ear' health visitors appeared to use skills which are derived from practice and life experiences.

9.7.1 Information gathering

Health visitors described a process of information gathering as central to assessment. These findings support those of an earlier study and suggest that health visitors often coordinate assessment data from a variety of sources (Appleton, 1993). A small number of health visitors described this as a two way process. Chalmers (1992) previously found health visitors and clients controlling and managing their interactions by selectively 'giving' and 'receiving' what is offered and accepted from each other. The co-ordination of assessment data and pulling together information from different professionals is often left to the health visitor and seems to take on a more prominent role where there are children in need concerns.

Figure 9.5: Strategies adopted to aid assessment



Background information gathering

Health visitors often undertook a considerable amount of background information gathering prior to a client contact, particularly if it was their first contact with a family. For example, before new birth visits health visitors would gather brief details from antenatal forms or later, from the hospital's birth notification slip, they might also liaise with the community midwife if any special needs were indicated. A minority reported drawing conclusions about a client's ethnic background from names on records and the potential for language barriers.

When families transfer into the area, health visitors would draw information from previous health visitor or GP records, although there was a general realisation that because of Trust requirements, practitioners may be obliged to visit a family before seeing any records. However in making professional judgements many relied on the belief that colleagues working in other areas would make contact with them if "*there were obvious concerns*" (HV 2.38:112). Certainly there was evidence in the study, of health visitors adopting this policy in practice and contacting counterparts in other areas.

Participants described health visiting records as a useful source of information, although pointing out the potential dangers of allowing previous records to lead to preconceived ideas about families. Health visitors also use other professionals, mainly GPs, social workers, midwives and liaison health visitors as sources for gathering further information about a client's medical history or a particular condition. HV 2.20 also described gathering valuable information from GP receptionists. Yet only three health visitors reported having such a good relationship with GP colleagues, that the GP would automatically liaise with them about information they perceived they needed to be aware of.

The process of background information gathering would continue as health visitors assess the social environment in which a family lives. This often began before reaching the family home. It was particularly evident in one case where a health visitor describes her initial impressions on approaching a terraced property:

> *... I got an impression of chaos, even before we knocked on the door you saw the little yard full of rubbish, dustbin, bins, items that could do with moving ...* (HV 3.49.4:169)

Information gathering during the client contact

It became evident that a considerable amount of information gathering took place during the health visitor/client encounter. This occurred in two ways, either actively sought and led by the health visitor or client led. In the former, information would be sought by the practitioner with the health visitor taking the lead and generally adopting

a questioning strategy to encourage the client to offer information. Conversely the client would take the lead, talking openly and freely offering information to the health visitor who would actively listen and acknowledge information received. Sometimes both approaches were observed in a single encounter.

Kendall (1993a) has previously described health visitors adopting such a question and answer sequence and is critical of this approach being used purely to gather a database of information rather than being used constructively to gather information which is relevant to clients' needs. HV 1.39 justifies adopting a questioning strategy to gather information about a client need in order to offer appropriate interventions:

> *Without asking questions you're not going to find out one what their knowledge base is and I mean if a child's got a sleep problem for instance I tend to ask quite a lot of questions ... and I'll say "oh seems like I'm asking you a lot of questions here but you know I need to sort of be clear about exactly what's happening and what has happened in the past before I can give you any advice" and normally they're quite happy with that ...*
> (HV 1.39:533-535)

Furthermore some clients commented how important they felt it was for health visitors to ask them questions to gather information. Client 2.91.1, who appeared quite under confident said that it was because her health visitor opened up discussion through questioning that she was able to talk to her. As Chalmers (1993) has suggested, questioning can be used to enable clients to be more aware of their own needs. Another client explained how her health visitor would ask "*general questions about how things are going*" (C 2.91.2:211) in a respectful way, never prying. This client described how the health visitor had used a simple question to open up discussion about the relationship difficulties she was experiencing with her husband. He eventually left to pursue a homosexual affair:

> *I'd gone in there* [the clinic] *and I think the baby started to cry and* [HV] *just took one look at me and pulled me into the other room and I just sat there and bawled and bawled and bawled and she didn't pry. She just sat and waited until I had sort of got it out and then I, you know, she said is there anything that I wanted to talk about?* (C 2.91.2:250-252)

There were plenty of examples throughout the observed contacts of clients taking the lead in conversation, with health visitors' actively listening and apparently gathering data around the expressed needs of the client. Information about clients was also gathered during home visits when health visitors actively responded to verbal cues offered by the client or when they sought permission from clients to undertake specific aspects of a child's developmental assessment.

9.7.2 Getting to know the client/family

During the accompanied visits health visitors frequently adopted a strategy of information gathering to enable them to get to know the client/family better. Cowley (1991) has previously described this concept in relation to health visiting, while Bryans (1998) found district nurses adopting a strategy of 'getting to know the patient'. Over half of the observed contacts included examples of health visitors gathering information with the intention of getting to know the client better and sometimes this included information about other family members to build up a picture of the family unit and past history. At the end of one visit as HV 1.39 was leaving she spent quite along time chatting to a mother about family photographs on the wall. She describes why it is important to try and get to know a family:

> *I ask a lot of questions about families when I visit them. I always ask what job the partner does, if there's a partner around. What job did you used to do before you had this baby, oh do your parents live nearby and you know, what do they do? I'm quite nosy in a way but it helps me build up a complete picture of the person I'm visiting ... and obviously then you know if in a future visit with that person I can say "oh well you know, how's your mum, she wasn't well last time" ...* (HV 1.39:160)

9.7.3 Adopting an informal stance and flexible approach

Throughout the accompanied visits all health visitors tried to adopt a friendly and informal approach with clients, even during more difficult encounters. During the initial interviews several practitioners described the need to be approachable and put clients at ease in order to gain access and undertake effective health visiting:

> *I think the skill is that it's being approachable to families so that they don't feel threatened and they can be put at ease to talk with you, that you're not going to probe to a degree where they're going to really stop speaking to you at all. I think one thing that always has to be remembered is that a health visitor is a guest in a person's house and on that basis then you have to take things very carefully ... I feel that I need to take the time for people to get to know me and feel comfortable with me ...* (HV 3.53:102-108)

Such informality was evident when practitioners engaged in general social chit-chat with clients before getting down to the business of health visiting. In some cases health visitors appeared to be using their personality engaging in gentle humoured banter in an attempt to develop informal relationships and put clients at ease. For example, when a father discussed contacting the school about his concerns regarding his daughter, the health visitor said "*not everybody has a hot line to the headmaster do they?*" (O 2.20.3:293), both parents laughed and immediately appeared to relax.

It was evident that many of the health visitors used their interpersonal skills and recognised the importance of developing a rapport with clients before launching into the activity of needs assessment. Previous research has highlighted the significance of health visitors' personal attributes, such as sensitivity and the ability to relate to clients when searching for health needs (Twinn, 2000). Several clients also talked about the importance of having a health visitor who was easy to talk to and puts them at ease.

Flexibility was evident throughout the visits and demonstrated in many ways. While all the health visitors tended to adopt a fairly relaxed stance, this was particularly noticeable with HV 2.77 whose approach to health visiting with all her clients was incredibly informal. During one visit she really seemed to make herself at home, sitting on the floor and at one stage stretching out and lying on her side while chatting with a mother and her boyfriend. The need for health visitors to 'go with the flow' was apparent in several visits.

> *I think basically it is having an agenda yourself but allowing that to go completely out the window if necessary ...* (HV 3.07:199)

Table 9.2 illustrates health visitors' willingness to move away from their own visit agendas.

Table: 9.2 Health visitors' home visit agenda and objectives

	Visit Objectives	Visit agenda			
	Clearly stated	Not changed	Unclear	Changes to address needs raised by client	
SITE A	1.15.1 1.15.2 1.15.3 1.15.4 1.25.1 1.25.2 1.25.3 1.25.4 1.39.1 1.39.2 1.39.3 1.39.4 1.39.5 1.70.1 1.70.2 1.70.3 1.70.4 1.82.1 1.82.2 1.82.3 1.82.4	1.15.3 1.15.4 1.25.3 1.39.1 1.39.5 1.70.1 1.70.3 1.82.2 1.82.3 1.82.4		1.15.1 1.15.2 1.25.1 1.25.2 1.25.4 1.39.2 1.39.3 1.39.4 1.70.2 1.70.4 1.82.1	To discuss mum's bereavement and cold To discuss mum's tiredness due to pregnancy and anaemia Client rushing to see husband in prison, no time for 2 year development check To discuss DLA, but HV does not pick up on mother's cue about 3yr old's behaviour regression To focus in more depth on mother's depression Client's past history and health problems; leaving baby for long periods (not addressed directly by HV but arranges to visit again soon) Mum's depression/low feelings, her pain and previous sexual abuse Main focus of visit was baby's health, pigeon problem appeared secondary issue Mum enabled to talk about her previous abuse by brother and attempted poisoning Client had own agenda to end period of increased support and HV followed suit Mum not wanting to discuss her concerns re teenage son today -? constraints of time and/or presence of observer. Also 3 mth baby on Diarolyte
SITE B	2.06.1 2.06.2 2.06.3 2.06.4 2.20.1 2.20.2 2.20.3 2.20.4 2.38.1 2.38.2 2.38.3 2.38.4 2.77.1 2.77.2 2.77.3 2.91.1 2.91.2 2.91.3 2.91.4	2.06.1 2.06.2 2.06.4 2.20.1 2.20.4 2.38.2 2.38.4 2.77.2 2.91.1 2.91.2 2.91.3 2.91.4		2.06.3 2.20.2 2.20.3 2.38.1 2.38.3 2.77.1 2.77.3	Multiple needs raised by mother relating to her own health Agenda changes slightly to focus on 3 yr. olds sleeping and 6 month baby's diet/feeds Parents raise need of 3 yr. old getting up at night – HV checks on safety issues relating to this but does not explore further (i) Child waking at night for juice (ii) Extended family problems Community Paediatric nurse turned up and weighed baby Client wanting special needs child to go to a local nursery discussed with HV Mum very tearful and eventually able to talk about how she would cope if child died
SITE C	3.07.1 3.07.2 3.07.3 3.49.1 3.49.2 3.49.3 3.49.4 3.53.1 3.53.2 3.53.4 3.71.1 3.71.2 3.71.3 3.71.4	3.07.1 3.49.2 3.53.1 3.53.2 3.53.4 3.71.2	3.07.4 3.53.3	3.07.2 3.07.3 3.49.1 3.49.3 3.49.4 3.71.1 3.71.3 3.71.4	Initial objectives addressed and new needs mother raises End of period of increased support, as clients moving out of the area To discuss changing baby on to bottle feeds – discusses later in the visit Needs raised by client about housing problems and HV addresses Length of visit cut short as mum had to go out Needs raised by client e.g. drug taking and family problems Mum wanting a nursery placement for 21 mth old to spend more time with special needs child Mum changes agenda from sleep problem to baby's rash – HV addresses

Health visitors demonstrated their competence by managing situations and dealing with the unexpected without being perturbed. On arrival at one home, HV 1.70.2 effectively diffused a mother's anger and soon calmed her down. In another situation, HV 1.15.1. visited a client who was staying temporarily with a friend after being victimised in her council home. At the beginning of the visit the friend was hanging up washing, then she came and sat on the floor and listened to the discussion taking place between the health visitor and young mother. HV 1.15.1 describes having to manage this situation:

> *... it was difficult and you know obviously it wasn't the way I'd intended or thought it would be but – it's just the way its turned out at the moment – yeah. Then you know, that's the nature of health visiting really, isn't it? You've got to go with what you find at the time.* (HV 1.15.1:234)

Flexibility was also demonstrated when other people were present, generally unexpectedly or if the client answered the phone during the visit. On the whole health visitors managed these situations with skill and tended to continue with the visit as if none of these distractions were occurring. Furthermore many practitioners demonstrated a flexible approach when organising subsequent appointments, trying to fit in a time which was convenient for the client.

9.7.4 Working in a way that is acceptable to clients

Another theme to emerge from the analysis was that health visitors attempted to work in a way that was acceptable to their clients. Although there was a general recognition that one cannot possibly get on with everyone because of the nature of human relationships. In striving to be acceptable this involved behaving in a way which is agreeable to the client/family. A number of dimensions were revealed in the data including:

- demonstrating respect by genuinely acknowledging the needs and difficulties faced by families
- reinforcing a client's actions
- being empathetic
- accepting client hospitality.

Several health visitors described that "*you adjust your approach*" (HV 3.53:63) to the client's needs by drawing on their knowledge and experiences of the client.

Working in this way was often important in the health visitor continuing to maintain access to a family. This was apparent with one family where there were concerns that a 16/12 old might be at risk of Munchausen's Syndrome by Proxy and the health visitor was anxious to maintain contact both with this child and family and the mother's sister and her son. Indeed health visitors seemed willing to make considerable efforts to ensure continued involvement with families.

This strategy was also demonstrated through the health visitor taking a genuine interest in any children present, interacting, chatting with youngsters and sometimes involving them in play activities, either as part of a developmental assessment or at other times to gain the child's co-operation and confidence. This strategy of involving the children was very much valued by clients. Furthermore health visitors also demonstrated respect by seeking parental permission prior to weighing or measuring a child or before organising a referral to another agency.

The emphasis on being a guest in a client's home continually emerged. Health visitors generally felt that it was important to accept client hospitality as this can be an important step in relationship building. Accepting a drink indicates that the practitioner will make time to listen to the client. The following health visitor adopted a very relaxed approach with one mother, graciously accepting tea and cakes as part of relationship building:

> *I think you have to go with their traditions and this is a Turkish family who are always very hospitable ... I think if you don't accept their hospitality you're denying them something and that's probably not fair and I think also when you're going to do a fairly long visit and chat about quite difficult things maybe it breaks down the barriers to some extent, even if I drank mine and she didn't touch hers. That's just the way it was. But yes, I think you've got to yes you've got to go with the flow* ... (HV 1.15.2:195-197)

Another strategy adopted by over half of the health visitors to further their relationship with and be acceptable to clients is through disclosure of information

about themselves or their family. By sharing personal information, health visitors demonstrated the human side of their personality. However, some health visitors were guarded in the fact that they would not share information about their private lives with all families. This tended to be because they did not feel comfortable enough to share information or because of concerns that it could belittle or undermine a client. One health visitor admitted to a client that she had lied about her child's age when visiting a theme park, saying the child was a year older in order to gain entry. This evidence that the health visitor was fallible and not necessarily an 'expert' certainly endeared her to her clients. One commented:

> *the one thing I like is, when I say to* [HV] *... when I feel like I'm not a very good mother because of this or that,* [HV] *will say, "well I've done the same with my children", and it's like, wow, she's a health visitor, and she's done something wrong, you know and there again, that again brings her onto a level with me. ... it's nice that she actually, she won't sit and talk about her children – but, she'll say, "oh, I remember when one of my boys did that."... You know, and, and that makes me think, well, no-one's perfect then ... it just makes me feel equal.* (C 2.06.3:391-397)

9.7.5 Gauging – playing things by ear

One of the skills of health visiting is the skill of knowing what to say, how much to say and when to say it. The notion of gauging is about recognising that parents may not be able or ready to address needs which are evident to the professional. This appears to reflect an embedded judgement. Gauging was often apparent in health visitors' work with parents with children with special needs. For example, one health visitor describes how her involvement with a family has centred on supporting a young mother over several years as she has gradually come to recognise her daughter's disability:

> *... She knows there's a problem but still she doesn't really want to hear anybody spell it out. I think it's just* [sighs] *for any parent I think with a child who's obviously got special needs problems it's an awfully difficult thing to come to terms with ... so you know it's a fine dividing line between being very honest and treading gently and not making them feel even worse than they feel already ...* (HV 1.15.2:155-157)

The uncertain nature of the future course of the child's special needs and especially in accepting that it is going to be an ongoing problem has been extremely difficult for the family to accept. This health visitor said that her skill and knowledge in learning how to play things by ear had been gained from her previous practice experiences.

Gauging also encompasses an element of treading carefully. This skill is an important component of successful relationship building to gain client co-operation and was particularly emphasised by health visitors in situations where they did not know clients very well. It also became evident, as Chalmers (1990) found, that health visitors tread carefully when clients are not ready to engage with, or feel they do not require the health visiting service. This concept is particularly apparent in cases where the health visitor needs to ensure that she gets access to the child(ren). HV 1.82.3 described needing to tread carefully in the case of a family where one child has previously been on the Child Protection Register and a Ward of Court. By adopting this approach she is able to maintain some contact with the family, trying to ensure the client does not withdraw totally from the service.

Such attempts to maintain access have striking similarities to the situations described by Chalmers (1990:79) where health visitors would 'keep trying' to gain entry in situations where there were concerns about children's safety or well-being. Treading carefully in order to ensure access was often discussed:

> *It's the unanswered question of all health visiting isn't it ... how you aid the family forward without pushing so hard they go into reverse.*
> (HV 3.49.2:285)

A minority of health visitors also described sometimes making a judgement not to raise potentially sensitive issues with a client, as well as ignoring obvious issues i.e. illegal childminding arrangements. They do this in order not to compromise their role and acceptability with a family and maintain access to the family home.

9.7.6 Use of assessment guidelines

As described in Chapter 6, only a small number of health visitors regarded formal assessment guidelines as helpful in aiding their assessments, with a minority adopting

this strategy in practice. Paradoxically very little emerged from the data about the use of such guidelines in practice, in complete contrast to the tremendous emphasis still being placed on the development of formal guidelines as discussed in Chapter 3. Despite the fact that the literature has revealed no solid search base supporting their use, there is a great legend that guidelines to identify families in need are eminently useful. It is surprising that there is so little to say about this issue, this finding in itself may well be unexpected.

9.8 Inhibitory factors

As part of the process of seeking alternative explanations for patterns in the data, a number of health visitor actions and associated factors were identified which may inhibit assessment or not legitimise clients' needs (Figure 9.6). These include:

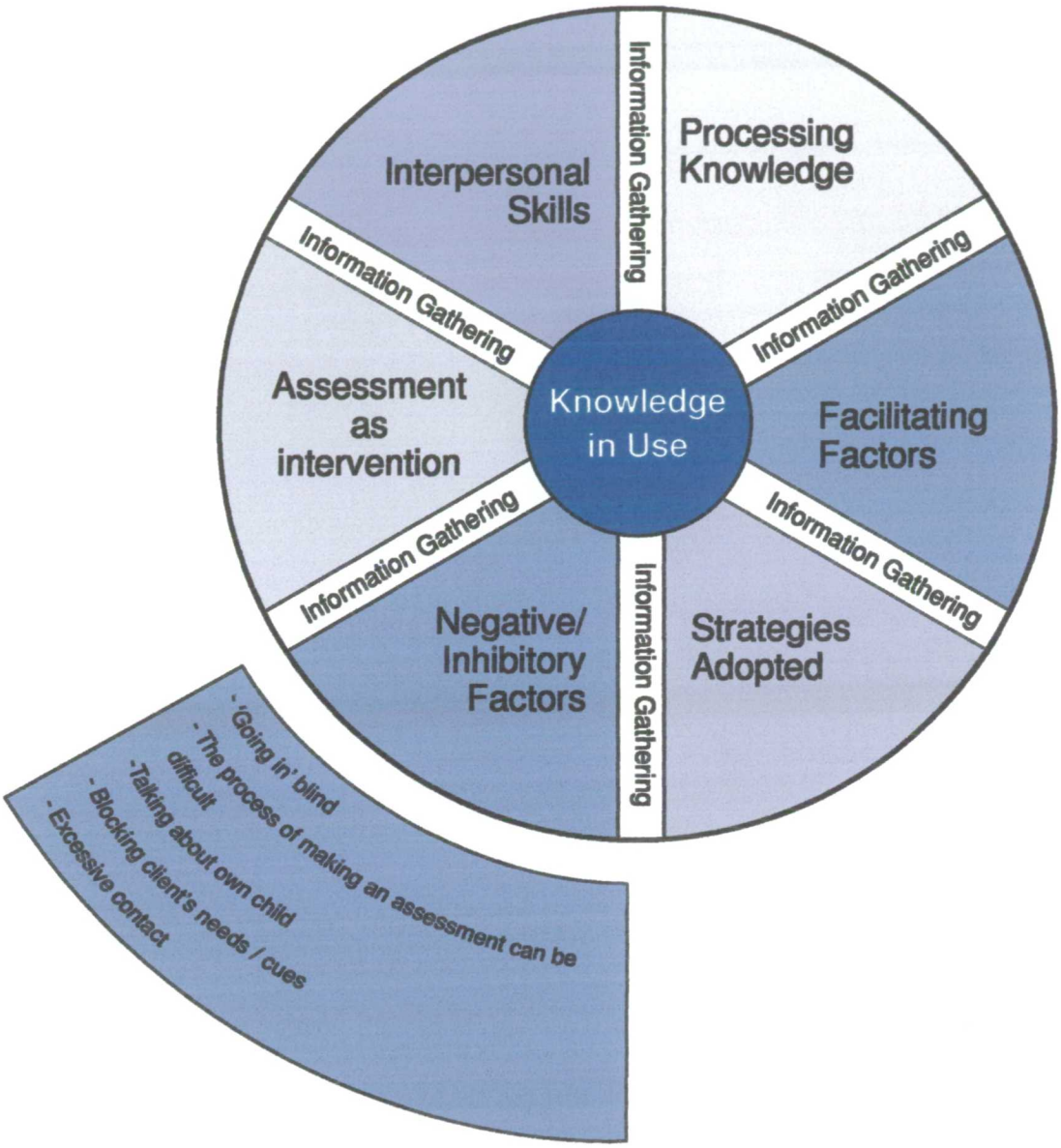
- 'Going in blind'
- The process of making an assessment can be difficult
- Talking about own child
- Blocking needs/cues
- Excessive contact.

9.8.1 'Going in blind'

In some situations a health visitor has no background information before making an assessment of a family's health needs. This is often the case on a transfer in visit where Trust policy and the recommendations outlined in the Patient's Charter require early visiting. With very mobile families it can take a considerable length of time to track down previous records, so health visitors find themselves entering family homes with little background information. One health visitor described the difficulties she has experienced in visiting families and finding that no-one in the family speaks English, so she has to return with an interpreter. Such difficulties are posed if practitioners have little knowledge about a family and their actual or potential needs. Health visitors also described 'going in blind' to new births, because of the limited contact most have with parents antenatally:

> *... where it's the first child in the family I have no information apart from the birth details so it is very much a new kind of situation and you never know what's going to be on the other side of the door.* (HV 1.82:384)

Figure 9.6: Inhibitory factors



In such cases and with limited opportunities for contact with families, health visitors are very reliant on their assessment abilities and skilled judgement in identifying families in need of increased support. Such a situation needs enormous confidence and a range of skills.

9.8.2 The process of making an assessment can be difficult

Making an assessment can be fraught with difficulties as the reality of practice is influenced by a whole host of complexities. One of the key difficulties which practitioners face is when clients are not aware of their needs, or unable or not ready

to address them. Indeed in some situations despite the health visitor identifying a need or problem, the client may just not wish to acknowledge its existence. HV 1.39 described an older couple, who have a four-year-old and a new baby where she has concerns about their parenting and nurturing skills. The parents seem to continually display negative feelings towards the older child and they speak to the baby as if talking to an adult. She described how difficult it is to work with these parents when they perceive no difficulties.

In some cases clients openly express needs but are not ready or willing to address them or be referred to other services. In such situations health visitors can do nothing unless they suspect child maltreatment and need to take action to protect a child. This may lead a health visitor to check out their professional judgements with a child protection advisor. Health visitors also describe the assessment process as difficult if they are unsure if the client is being honest. There was a general view that clients need to get to know their health visitor before feeling able to raise needs with them. On a more personal note one health visitor (HV 3.71) suggested how her own personal insecurities and feelings about a client, made her not want to be honest about what she was observing in one practice situation.

Health visitors suggested that needs can be missed for a number of reasons. The constraints in current service provision (highlighted in Chapter 6) and the limited nature of core programmes means that practitioners are increasingly likely to miss needs when making their assessments. A single contact may indicate everything is all right when in fact this is not the case. Health visitors also believed that sometimes they miss client cues, "*the signals aren't always picked up*" (HV 2.06:102) or professional judgement is marred by the client giving an inappropriate or limited response.

Furthermore many clients do not wish to or are unable to attend clinics, so needs may not be uncovered as a result of limited family contacts. As noted in Chapter 6 there is a management assumption that clients will seek out professional assistance when needed, but in reality vulnerable people are rarely able to do this. Clients who move frequently are likely to have less contact with health services and therefore risk falling through the net because their needs are not picked up.

The process of assessment may also be difficult when assessment data does not make sense, when the health visitor is seeing one thing and being told another. In such situations practitioners may experience difficulties in unpacking their concerns about a family. Finally although having made an assessment, the outcome may be problematic if there are no resources to refer the family on to.

9.8.3 Talking about own child

It was highlighted earlier that as part of the strategy of working in a way that is acceptable to clients, sometimes health visitors would disclose information about themselves to clients. The majority of clients felt comfortable in knowing that their health visitor was a parent and could draw from their own parenting experiences, as one father said:

> *we've always felt that you know she's always understood because she's a parent herself.* (C 2.20.4:483)

Other clients found it useful if their health visitor drew on the perspectives of other parents to offer them tips. One practitioner routinely sought "*parenting tips*" from clients to pass on to other parents, which her clients really valued. She also offered 'general' suggestions on parenting:

> *if all the time I am making it specific to her, it can be too much, and easily critical. If it's a general point about parenting, it enables me to, to discuss parenting issues in a much more general sense without seemingly to be getting at her.* (HV 3.49:283-285)

While this aspect of practice was valued, some parents clearly disliked health visitors referring to their own child(ren). One mother said:

> *if I've got some problem with a child, she seems to sort of like, refer back to her child - "I used to do this, and do that", and I just think, well, you know, I don't quite know if that's going to work for me, the same as what it did with your child ...* (C 2.20:23-25)

When health visitors referred to their own children in this way, it often had a negative effect on the encounter.

9.8.4 Blocking needs/cues

While health visitors clearly recognise that they can sometimes miss cues, during some interactions practitioners visibly blocked cues raised by clients. Sometimes health visitors would apparently ignore a client comment or question and change the subject. As highlighted on page 190, this might be a deliberate strategy if a health visitor is extremely busy or stressed. Occasionally health visitors would respond passively as the following sequence illustrates. This mother had recently taken an overdose, following a history of abuse by her partner, who was eventually imprisoned. On his release he attacked her again and wrecked her home. Her father is under arrest for sexually abusing herself and her sister:

HV: *And what's the counsellor going to do? Are they going to send you another appointment.*

R: *Yes. They said they would do yes.*

HV: *Yeah.*

R: *And erm I 'ad a psychologist appointment for later, they said they'll send me another appointment because he's booked up for quite along time ...*

HV: *Oh right.*

R: *It's going to be eight week or nine week time ...*

HV: *Hm mm – I would think probably once you've had these appointments maybe they can sort of help direct you in the right place sort of to help sort of to get you through time ...*

R: *But nobody 'elps and I'm going backward all time, nobody 'elps ...*

HV: *Mm, mm.* (O 3.53:89-97)

This visit took place at the mother's sister's house where she and her two-year-old were staying temporarily, while waiting for the council to refurbish a derelict property. Later during the visit, the health visitor continues to ignore cues raised:

C: *And I 'aven't hardly eaten anythin' just a bag of crisps whatever...*

HV: *Mm, mm.*

C: *I 'aven't any 'elp ...*

HV: *Mm ...* (O 3.53.1:104-107)

She later responds by asking a question and changing the subject, which essentially blocked this client's cry for help:

C: *Yeah I don't know what else we 'ave to go through to get 'elp...*

HV: *Mm, yes. They're very, they're very hard going at the moment are the DHS they've really, really cut down on the kind of help they'll give yeah ... Do you and your sister get on well then, are you pretty close?*
(O 3.53.1:140-141)

The client found this health visitor's inability to respond to her cues quite frustrating:

I think she should be able to suppor' me more as she knows I don't ge' any 'elp from anywhere else ... You know talk about the situation with me, she seems to shut conversation off you know ... Well I'd like 'er to 'elp me more with 'ouse, I mean she just you know once I mention it you know it's it's all gets shut off – I mean that's what I thought she was there for to 'elp me ...
(C 3.53.1:161-167)

Kendall (1993a; 1993b) has previously identified similar non-empowering strategies being adopted by health visitors. Although such blocking of client cues was only evident at a small number of visits, when it did occur it removed any opportunity to explore further client needs or offer health promoting advice and seemed to have a negative impact on the whole visit. For example one client (C 1.70.4:178) felt that she would have liked more advice from her health visitor in managing her baby's sleep problems, but felt the health visitor effectively blocked discussion by responding with a "*standard response*" which negated further discussion. Kendall (1993b) criticised health visitors offering this type of stereotyped advice.

9.8.5 Excessive contact

A small number of health visitors believed that excessive client contact might lead to dependency and have a negative impact on enabling clients to deal with and take responsibility for their needs. Clients and health visitors felt that it could increase client anxiety. Some professionals felt that frequent visits do not encourage parents to be self-confident and autonomous:

> *If you start visiting lots of times it's like a declaration of no confidence and the times I've done extra visits because I was worried, I feel as if I've ended up undermining them rather than building them up ... because I always aim, however chaotic it is to build on what is right rather than make them feel inspected and failed and if I go often ... it is as if I am just not seeing their strengths and daring to leave them and I have found I have regretted it ...* (HV 3.49.4:153-155)

Views about 'popping in' to see clients unexpectedly were mixed, with the majority of practitioners indicating that this perpetuates a notion of policing families (McIntosh, 1986; Mayall and Foster, 1989). Worryingly, a minority believed this practice was acceptable (1.70; 2.20; 2.38; 2.53) with one health visitor saying:

> *It's just a monitoring, if you like of the situation. So you don't necessarily have a real clear objective for going. It's in any case to see how things are progressing.* (HV 3.53.3:147)

This health visitor appeared to adopt this strategy with families with on-going problems and could be criticised for offering few obvious health promoting interventions.

9.9 Intervention strategies linked with assessment

An interesting feature of the analysis was the fact that health visitors' assessment strategies were frequently intertwined with intervention activities directed at further clarifying or raising awareness of health needs. As Chalmers (1993:904) previously identified "*often multiple processes occurred at the same time*" with health visitors apparently assessing one need while searching out and raising awareness about others. Although Chalmers (1993) identifies this feature she does not pursue in any detail the sorts of strategies which seem readily interlinked in practice and provides little detail about the nature of these assessment interventions.

During the current study several different interlinking assessment/intervention strategies were identified (See Figure 9.7). These were:

- Normalisation
- Being realistic - Facing reality
- Encouraging self-reliance
- Making the health visitor assessment visible to the client
- Talking through options;
- Praise and acknowledgement
- Interventions to raise client awareness
- Summarising and feeding back
- Positive reinforcement.

9.9.1 Normalisation

Health visitors frequently used normalisation when making an assessment of a child's developmental progress or behaviour. The apparent intention of this intervention strategy is to offer reassurance to a parent that the child's behaviour or development as assessed by the practitioner reflects the normal or expected range. It is usually preceded by a client cue. In the following extract mum was concerned about her 3-year-old's soiling:

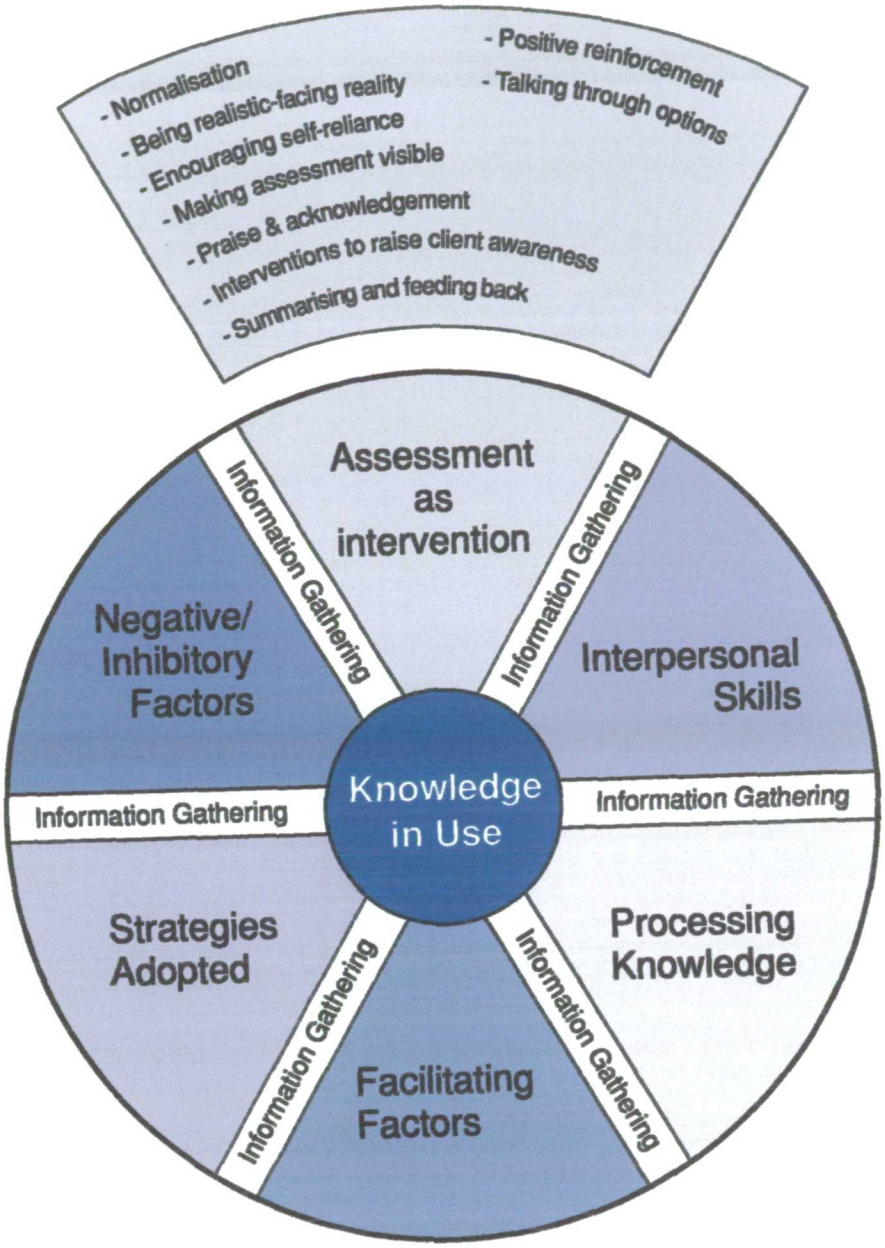
C: *What upsets me with* [child – 3 years 2/12] *is he's not bothered to go upstairs to the toilet and he soils himself sometimes because he's not bothered to go up the stairs. He'll go at the last minute*

HV: *But most small children do that... because they're so busy playing ...*
(O 1.70.2:228-231)

9.9.2 Being realistic - facing reality

This involves the health visitor exploring and assessing a need with a client through listening and discussion, while simultaneously getting the client to be realistic about the situation being faced. This approach often entails a lowering of unrealistic expectations. The intervention is largely practitioner directed with health visitors offering advice in response to client cues. Cues often relate to children's growth or development, service resources or the client's situation. This strategy involves the practitioner gently suggesting a more realistic explanation or alternative.

Figure 9.7: Intervention strategies linked with assessment



For example, during one visit a health visitor assessed through discussion with a new mother, that she was expecting her 3-week-old baby to have developed a feeding pattern. At the same time the health visitor was able to reassure mum and advise her this is unlikely to develop so early. She said:

> *I think it will probably come, when you get a bit more routine with her feeding but it's still, it's still very, very early days and not many babies stick to the same feeding time everyday, it will change from day to day and the fact that she will go sort of for a four or five hour gap now is better than it was ... and I think you just need to sort of persevere and be patient. It's very difficult when you're tired ...* (O 1.39.2:42-44)

By intervening in this way the health visitor was able to alter the client's perspective without undermining her confidence. The mother later said:

> *... Maybe I am expecting too much of her ... I'm thinking there's me talking about her sleeping through the night and* [HV] *sort of puts it in perspective like "well she's three weeks old, you know, you've got to wait a little bit longer before you start thinking about that" so. I think yeah I'm trying to rush things really with her ...* (C 1.39.2:166-167)

Being realistic sometimes involved health visitors providing information or an honest account, in response to client cues. During one visit a health visitor uncovered a mother's fears that her 2-year-old would die during forthcoming major heart surgery and her fears about how she would cope with this horrific scenario. The health visitor was able to provide the mother with practical information about what would happen in the event of her child dying, yet she was also able to emphasise the need for her to keep thinking positively. It was a very moving visit with the client in tears and at one stage the health visitor hugging mum. This mother was clearly relieved to have had the opportunity for someone to acknowledge and discuss her fears with. She later said:

> *I mean* [HV] *said just now well you know if something did happen to* [name] *that there would be support there. But then my family would say – well don't worry nothing's going to happen to him anyway ...* (C 2.77.3:190)

The health visitor later described how important it was for her to respond to this client's cues.

9.9.3 Encouraging self-reliance

This strategy involves practitioners empowering clients to examine their own situation afresh, getting them to start thinking about how they can move forward themselves and encouraging the client to take control. It involves similar elements to being realistic and facing reality, but while the latter tends to be health visitor directed, here the onus is on the client. For example HV 1.25.4 was observed to explore how a single mother could balance her child care responsibilities with her employer's demands and her own physical exhaustion by asking the following open ended question, *"So how can you work round that?"* (O 1.25.4:63)

Encouraging self-reliance involves the health visitor assessing while at the same time intervening to enable the client to look at and consider the practicalities of their situation. This was sometimes directed at getting the client to think about the causes or antecedents of problems. While assessing a mother's coping abilities, HV 3.71 explained how she could work with her to enable her to begin to sort out her problems herself. The emphasis is on the client doing the thinking:

> HV: *I mean obviously I can't solve anything for you but what I can do is support you and sort of help you find some answers for yourself.*
>
> C: *That's what I need.* (O 3.71.1:371-372)

Encouraging self-reliance also involves enabling the client to take some action. During one visit a practitioner assessed a mother's mental health needs and simultaneously encouraged her to make her own referral to the CPN, which on my return visit the client told me she had done. Another used this strategy, while assessing a mother's coping abilities and interactions with her children, by empowering the mother to put a request for a nursery placement in writing.

This strategy often centred on empowering client decision making, whether the decisions were minor or more important. Some health visitors while assessing client needs would actively ask the client for ideas on how they could improve the situation. Despite Hogg and Worth (2000) finding some clients critical of this approach, one practitioner justifies using this strategy:

> *I think it's sort of quite undermining if someone comes in with all of the ideas, I don't think that's helpful at all to do that so I often do ask, you know what can you do, or what would you like to do.* (HV 3.71.1:249)

9.9.4 Making the health visiting assessment visible

One of the most commonly used interventions adopted by health visitors involved raising clients' awareness about the health visiting assessment. This includes a practical visible element often combined with the health visitor talking through her assessment with the client. Sometimes this intervention strategy would be combined with positive reinforcement about how well a client is doing or positive comments

about a child's progress. (Although it is important to note positive reinforcement was also used as a separate intervention strategy.)

This strategy involves the health visitor conveying her assessment of the baby or child to the parent. In some cases multiple activities occurred simultaneously, health visitors would comment on a baby's progress while communicating with the baby as well as talking to mum. During one visit, HV 1.70 physically assesses a 5-month-old triplet:

> *what a clever girl, that really is good. Nice straight back isn't there, yes nice straight back and go back down again. No head lag at all, Brilliant, absolutely brilliant. Yes. Do you still think she's a bit too big? 'Cause ... do you know though* [mum] *she's so well proportioned ...* (O 1.70.1:5-7)

Such intervention activity appeared to lead to a range of outcomes including reassurance to the client, who is able to see an improvement or progress. It can also give the client the confidence or skills to make their own decision, therefore empowering client action and choice. It was interesting to find that health visitors frequently drew comparisons while making their professional assessment visible to a parent.

This intertwined strategy was sometimes used to reinforce a parent's conclusion that a child is unwell and therefore important as an intervention in confirming parental assessments. It was also used during one visit (O.2.06.3), where a mother expressed concern that her 9-week-old baby was very unsettled and screaming during feeds. This was an experienced mother, yet the health visitor assessed the baby's physical health and at the same time intervened to raise this mother's awareness. She did this by describing her assessment of the baby and through her questioning attempted to get the mother to recognise that her baby's behaviour was not normal. By making her assessment of the baby visible to this mother, the health visitor appeared to be putting the onus back on to the mother, getting her to take responsibility for her child.

Health visitors frequently made their assessments visible when showing parents that babies were gaining weight, by weighing the baby and plotting their weight on a centile chart for parents to see. This health visitor describes how this strategy helped her to show a young breast-feeding mum that her baby was doing well and thriving.

At the same time, she was intervening to promote health, by using this strategy she was able to convince the mother that she was producing enough breast milk:

> *in actually weighing the baby, that was another sort of like visible tool for mum ...* (HV 2.38.4:78)

Another practitioner said she used this strategy to make her assessment of an 8-week-old baby's weight visible for the mother because despite the child being ill he had lost no weight. As an intervention the aim was to reassure and calm the mother. Later during the visit she adopted the same strategy while undertaking the toddler's 18/12 developmental assessment. Firstly she made the assessment visible to the client by assessing and commenting on the child's fine motor control, while later addressing his gross motor development: "*He's squatting. He's walking nicely*" (O 2.77.2:342). Following the visit she described using her judgement and experience to conduct the 18/12 assessment, demonstrating that she was actually "*doing something*", so that the mother could see the progress in her son's development. She describes it as going through the motions, despite knowing the child well and having a full awareness of his developmental capabilities. This intervention clearly had the desired outcome for the mother:

> *I didn't realise she was gonna do so much.* (C 2.77.2:154)

9.9.5 Talking through options

This strategy was closely intertwined with and built on health visitors' information gathering, as a response to a client's verbal cues or direct questions. However, unlike 'encouraging self-reliance' where most of the onus is placed on the client to identify how to move forward, in this intervention strategy the health visitor takes a lead in talking through available options that the client might wish to take. This includes exploring possible consequences of following a course of action, with the overall intention of empowering the client to take control or make a choice about action/non-action.

This approach involved health visitors assessing and attempting to address a need raised by a client, by exploring all the alternative courses of action, but all the time

continuing to make an assessment. A practitioner adopted this strategy with a young mother who has faced multiple problems including abuse by her step-father, who was imprisoned for sexually abusing her sister, but who is soon to be released and sending her threatening letters. When the health visitor first started offering extra support, this mother had serious debts through taking out a 79% APR interest loan, her relationship with her boyfriend, the father of her 18-month-old child was also breaking up. This health visitor describes how she discussed the options available to this mother, but emphasises taking a neutral position and facilitating the client to decide how she was going to manage her situation.

While making an assessment this health visitor would talk through the possible consequences of the young mum taking a certain course of action. She described it as follows:

> *I think one of the examples was talking to* [Ex-boyfriend]*'s parents and I got her to talk through what the consequences would be of that happening and what would the worst thing that happened what was you know what could be the best thing that happened at that point and just helping her to think through that, she was able to then to make a decision about what she felt that she could do and that was you know that was her decision.* (HV 2.06.2:81)

Such assessment/intervention strategies were not divisible and while a health visitor was assessing, clients seemed to appreciate the opportunity to talk through available options. One first time mother who had a caesarean four weeks previously and was breast feeding her baby, described how helpful it was that her health visitor did not tell her what to do, but instead offers her a series of options:

> *... she doesn't just say "do it like this and this is it – this is what you've got to do." It's she gives you options. She says you know if this doesn't work try such and such and it's just knowing all those different things ... She's very open minded and she'll you know try and give you different things to try and – which is good.* (C 2.38.4:168-173)

9.9.6 Praise and acknowledgement

While gathering health assessment data about actual and potential health needs a minority of health visitors would also actively praise and acknowledge clients. This intervention appeared to positively promote client well being. For example, when a mother describes that she has been able to deal with her baby's sleep problems and frequent night time waking, her health visitor praises her efforts in getting the baby into a new routine:

> *Well you've done very well because it's never easy you know.* (O 1.15.4:73)

Another practitioner justifies using this approach:

> *What I used to do, was to say, "is he doing this, is he doing that?" It's so easy to do in clinic, "is he crawling, is he talking, is he sitting? " But if you do it like that, you are risking that they have to say no ... or fib, which immediately puts them down, whereas if they tell you what they can do, you can praise them, and then it immediately puts them up. And it's, it's such a clever little device. So simple, really.* (HV 3.49:452- 460)

This health visitor sometimes tagged a piece of education onto praise and acknowledgement as one way of sharing information with a parent.

9.9.7 Interventions to raise client awareness

Exploring and assessing a health need with a client would often result in the health visitor raising the client's awareness about an aspect of that need. This was done either by talking with the client or demonstrating through role modelling. This approach was often adopted to raise clients' awareness about potential hazards to child(ren) in the home environment. Some health visitors used this strategy to raise client's awareness about the particular message that could be gathered from their child's behaviour. Sometimes this was achieved in the way a particular question is phrased. For example, is the child displaying attention seeking behaviour because he is boundary pushing or trying to make his/her presence felt? In these situations the health visitor would try and raise parental awareness by offering a possible explanation for the child's behaviour.

Health visitors would sometimes combine assessment, while carrying out an intervention to raise client's awareness about the importance of acknowledging children's presence. So while assessing the interaction taking place between parent and child(ren), a health visitor might also be demonstrating by example and stimulating awareness through role modelling. This approach has been previously described by Chalmers (1993). One health visitor while assessing family dynamics, described distracting the children during the visit by talking to them. She justifies using this approach:

> *To show mother that sometimes she, although she can have a conversation she can still relate to the children.* (HV 1.70.2:433).

During another visit the parents of a 6-year-old described how his teacher is constantly picking on their son and complaining about his behaviour. Through discussion the health visitor was able to raise these parents' awareness that their attitude to the teacher, (the mum openly admits to not liking her) and the sorts of negative things they are saying about her in front of their son may be having a destructive effect.

One health visitor when assessing would talk generally about parenting to raise parental awareness:

> *It's also another example of where we're talking about parenting in general. I'm not saying "do you think your child will roll off the sofa?" I'm just saying, what can happen to kids at this age?* (HV 3.49:488)

9.9.8 Summarising and feedback to client

Summarising then repeating or feeding back to the client what they have seen and heard was a very common strategy used by health visitors. They would often engage in quite a long conversation with a client before summarising and giving feedback. This activity has one of three purposes:

- to check out the professional's assessment
- to acknowledge to the client that she has heard what the client is saying
- as a display of empathy.

By combining these multiple approaches, this often resulted in the client opening up and talking further about their needs.

Checking out

While searching for and exploring health needs with a client health visitors would often adopt this approach, albeit rather tentatively to check out that their assessment is correct. The intention is to clarify what the client is saying and feeling, to ensure that the health visitor is understanding things correctly and to uncover other needs. Interestingly the summary is often presented as a question or concluded by a question. HV 3.71 used this strategy to reflect her assessment and observations back to a mother about her feelings about her baby's developmental delay. The health visitor seemed to pick up on the mother's guilt feelings:

> *It sounds as though you were saying then that you think perhaps she's a little bit slower because she has been ill and also I get the feeling that you're also blaming yourself about some of that* [name] ... *Would that be right?*
> (O 3.71.3:206)

When summarising and feeding back to the client health visitors would often use their own words and précis what they have been told. Sometimes this would be a very simple intervention/assessment strategy, with the health visitor almost repeating word for word what the client has said.

Acknowledgement

Summarising and feedback was also adopted to acknowledge what a client is saying about their situation. Thus by reflecting back the health visitor is able to demonstrate she is listening, understanding and being supportive to the client. Two health visitors (2.06 and 3.49) also used this summarising device to incorporate a piece of advice when feeding back to the client.

Displaying Empathy

In some situations the action of summarising, acknowledging and feeding back incorporated a deeper dimension through a display of empathy by the health visitor. During one visit a practitioner summarises her assessment, that she is listening and

understanding the turmoil felt by her client in her dealings with social services, which leads to a demonstration of empathy. Mum got very tearful when discussing her experiences:

HV: *So you feel very let down?*

C: [Crying] *It's the system. And they force people like* [Social worker] *you know to lie and corrupt and destroy ... they gave me another social worker and another one and another one. Everytime you got close to one, they took them away.*

HV: *That's how it's always been for you isn't it? As soon as you know they've never allowed you to make a sort of stable relationship with anybody.* (O 1.82.1:90-92)

9.9.9 Positive reinforcement

Another simultaneous assessment intervention strategy was that of positive reinforcement used by health visitors to reinforce any progress clients are making or to support client decision-making. This approach is driven by the health visitor and the focus is client orientated, centring on a client's actions or their progress in addressing identified need(s). The health visitor's emphasis is always on highlighting positive progress and generally focuses on how an adult has moved forward or how the adult has helped a child progress or managed a difficulty. It is a strategy that recognises "*parenting is hard work*" (HV 1.25.2:364) and is particularly valued by clients:

> *It is nice for someone to say you know, "that's alright, you're doing the right thing" ... cause like most of it surrounds me not her* [the baby] *... which is really good.* (C 1.39.2:166-171)

During one visit where the mother has a history of anorexia and depression, having been suicidal post-natally and had a lot of difficulty bonding with her child, the health visitor continually adopted a strategy of positive reinforcement. Prior to the visit, the health visitor described how the mother and her child's needs were so closely intertwined that it was difficult to separate them and how "*everytime there's a crisis in mother's life,* [the] *child loses weight without fail*". During the accompanied visit, health visitor 1.70 offered the client a lot of positive reinforcement about her progress.

At one point she said:

> *Marvellous. Yeah, well done ... looking back over the last eight, eight months, I think you have come a long way, and you know, you really should be proud of yourself, the way you've, the way you've lifted your head above the parapet.* (O 1.70.4:142)

9.10 Combined assessment/intervention strategies

In many situations health visitors would combine two or more intervention strategies. For example by assessing and normalising a 5 and 9 year old's behaviours, HV 1.39 was able to promote family health by raising a mother's awareness about how good the children's behaviour had been during the visit.:

> *I think they're normal typical, noisy children this morning. But they've actually been quite good.* (O 1.39.3:350)

However this assessment was a secondary issue as the visit centred on the health visitor supporting and listening to mum, while assessing her multiple physical and mental health needs. Indeed this mother was on the edge of a nervous breakdown. Yet despite this, the health visitor was able to sensitively draw her attention to the children's need for attention through praise or hugs. The health visitor discussed this diplomatically while acknowledging how difficult it must be when mum is so tired and exhausted herself.

9.11 Summary

This chapter has explicated the seven key elements that constitute the activity centred methods of the health visiting assessment process. Some elements, particularly those that are new in this model of assessment have been detailed at greater lengths than others, in an attempt to unravel some of the complexity of these process elements. Health visitors' co-ordinate data from a variety of sources in order to assess family health needs and formulate professional judgements. The analysis suggests that health visiting assessment is a complex interactive activity. It is important to be clear that many factors are interlinking and occur simultaneously. A key finding of the analysis is the fact that assessment is significantly intertwined with many other factors. Furthermore because of the individuality of the health visitors each would place a slightly different emphasis on these factors in relation to unique family contexts.

Chapter 10

The Reality of Extra Health Visiting Support

10.1 Introduction

This chapter will discuss health visitors' and their clients' views about the nature of extra health visiting support. The chapter begins by presenting a conceptualisation of the continuum of extra heath visiting which highlights the dynamic nature of this concept. A classification of extra health visiting is offered. The analysis suggests that there are different degrees of extra health visiting which appear to relate to the type of client/family needs and the health visitor's level of concern about children and their families. Extra health visiting is not a static concept, but shifting and variable and largely dependent on a professional's judgement about a family's current needs, their support mechanisms and coping abilities. The chapter explores the range of needs of clients and families in this study who were receiving extra health visiting and the extent to which clients were involved in that judgement. The latter part of the chapter moves on to examine clients' perceptions about the effectiveness of health visitor interventions in identifying and addressing their health needs.

10.2 The nature of extra health visiting support

Health visitors participating in the study across all three sites were largely in agreement that extra health visiting (sometimes termed increased family support) equates to client contacts that are additional to the core child surveillance programme, as documented in Chapter 6. Participants described the dimensions of increased support as incorporating not only extra health visiting, but also support gained through referral to other agencies. It might also involve working with a client to help them find support within their existing circle.

In the initial interviews many practitioners talked about extra health visiting being 'with the agreement of the family'. There was a general view that this intervention has to be mutually agreed, with a willingness on the client's part to accept help and work with the health visitor. As such there are of course families who will refuse to cooperate; those who continue to avoid contacts, or those who are unable to make use of what is on offer despite having many needs. Thus increased health visiting support incorporates a number of elements: it has to be a two-way process, the client must give their agreement to work with the health visitor to address health needs and a recognition that this process takes time.

There was a consensus view that increased family support can vary depending upon the extent of family needs and the health visitor's level of concern about children and families, from very minimal extra input to intensive contact with a family, perhaps daily or several times a week. Realistically extra health visiting will also vary in its extent and nature depending on resource availability in primary care and the time constraints and demands of an individual health visitor's caseload. A continuum of extra health visiting support is illustrated in Figure 10.1, which highlights the dynamic nature of this concept. Extra health visiting is not static, but shifting and variable and largely dependent on a professional's judgement about a family's current needs, support mechanisms and coping abilities. This was apparent across all three study sites and would support Cowley's (1991) contention that managing such complexity is a central feature of health visiting practice.

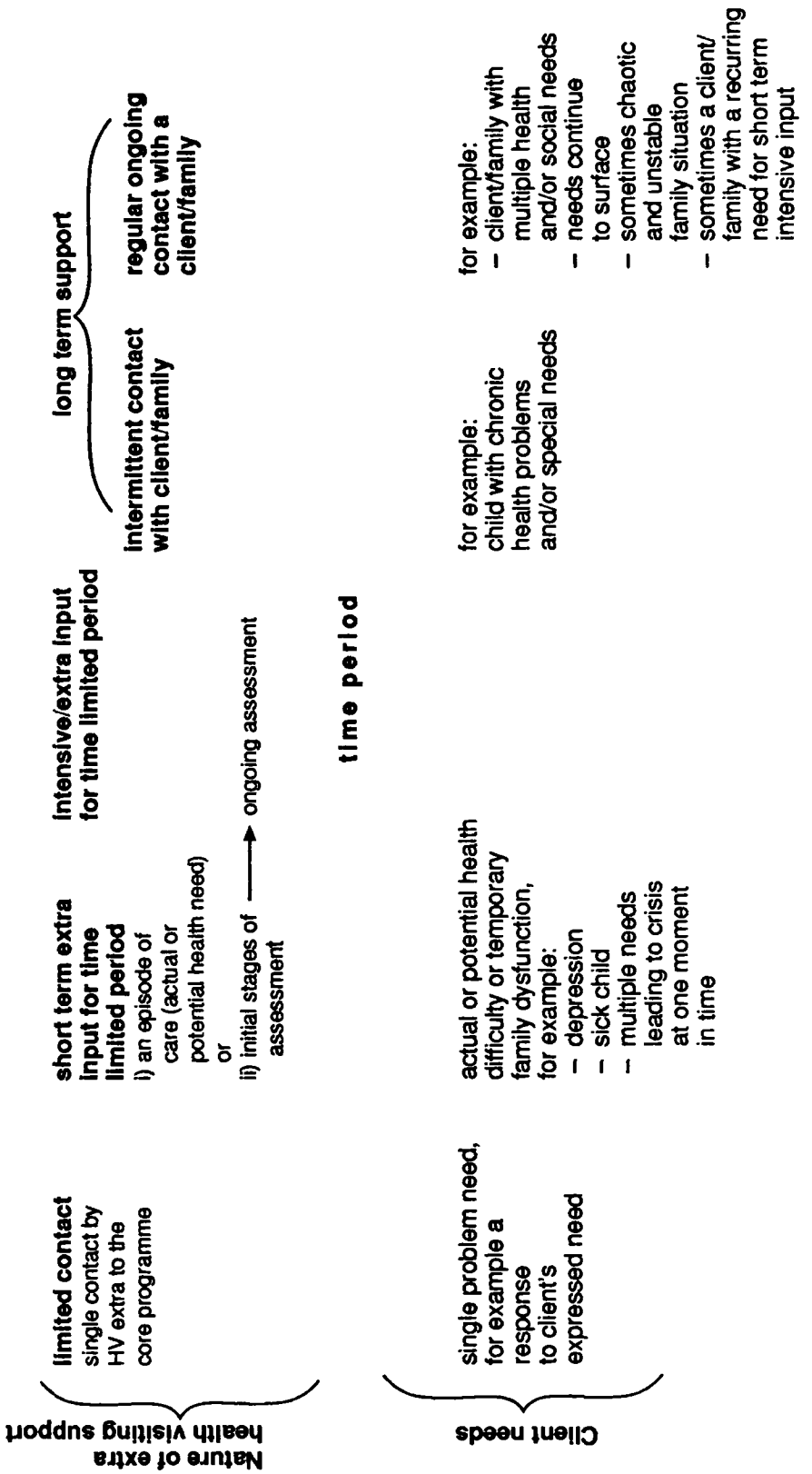


Figure 10.1: The continuum of extra health visiting support

Table 10.1 provides a classification of the 'extra health visiting' offered to clients in this study. Extra health visiting could relate to a single, one-off contact or at the other extreme be intensive and on going.

Table 10.1: A classification of extra health visiting

Nature of 'extra health visiting' support	Client/family need	Site A	Site B	Site C
Single, one-off contact by health visitor *	A response to a client's expressed need (or single problem/need).	1.39.4		3.71.3 3.71.4
Short term extra input for time limited period	Actual or potential health difficulty or temporary family dysfunction.	1.25.4** 1.39.1** 1.70.1**	2.06.2 2.38.1 2.38.2 2.38.3** 2.38.4 2.77.2 2.77.3 2.91.1	3.07.3 3.07.4 3.49.1** 3.49.3 3.53.4 3.71.2
Intensive visiting and support for client/family – initial stages of assessment	Acute health difficulty or temporary family dysfunction.	1.39.2 1.82.1	2.06.1 2.06.3	
Long term support – health visitor maintains intermittent contact with client/family	Child with chronic health problems and/or special needs. Family needs relating to this.	1.15.1 1.25.2 1.25.3 1.39.5 1.70.3	2.06.4 2.77.1	3.53.3
Long term support – frequent, regular (intensive) and ongoing contact with client/family	Client/family with multiple health and/or social needs /problems. Needs continue to surface and/or are ongoing. Chaotic and unstable family situations or clients with a recurring need for short term extra input.	1.15.2 1.15.3 1.15.4 1.25.1 1.39.3 1.70.2 1.70.4 1.82.2 1.82.3 1.82.4	2.20.1 2.20.2 2.20.3 2.20.4 2.91.2 2.91.3 2.91.4	3.07.1 3.07.2 3.49.2 3.49.4 3.53.1 3.53.2 3.71.1

* HV may refer client/family to another member of the health visiting team e.g. nursery worker or play worker.

** For potential need

10.2.1 A single one-off contact

A professional judgement to offer extra health visiting as a single, one-off contact occurred in one situation when both parents called to see the health visitor and requested a home visit to discuss their children's behaviour. HV 3.71.3 responded by undertaking a home visit to make an initial assessment, during which the mother requested a nursery placement for her 21 month old son, so that she could spend more time with her developmentally delayed baby. After a lengthy discussion, in which the health visitor

attempted to explore and elicit the family's needs, she offered the client a weekly visit from a playworker as a stop gap, while agreeing to support a nursery placement application for the older child. No further extra health visiting contact was planned.

10.2.2 Short term extra input/support

With several families, health visitors offered extra input for a short term, time-limited period, in an attempt to address a health difficulty or temporary family dysfunction. In other situations health visitors had identified a potential need and were conducting extra support in order to continue to assess the family situation or to check out their professional concerns. For example, one health visitor offered a single, first time mother with a young baby continuous support, because her "*nursing diagnosis*" (HV: 1.25.4:1) led her to suspect that the mother might be at risk of post-natal depression. However, rarely was the health visitor's professional judgement about such potential needs shared with the client. While health visitors could be criticised for not being 'open' with clients, arguably they may adopt this strategy to avoid raising parental anxiety needlessly.

With other clients, where health needs were obvious and acknowledged by the client, health visitors would undertake short-term intensive work, offering a range of input. In such cases needs tended to be short term and easily dealt with. However, only three health visitors clearly indicated to clients that the extra input would be for a limited period.

The period of time spent by health visitors with families in this study on short term intensive support varied from 3 weeks to 6 months and the frequency of contact between health visitor and client varied depending on the individual client needs, as one mother described:

> *Recently it's been once a fortnight, going on to once a month. If I have bad days I tend to call her out on a weekly basis ...* (C 2.77.3:167)

In a few cases health visitors were offering families intensive visiting, but were still in the initial stages of assessment and uncertain whether extra support was going to

be required for a short period or longer. In these situations, health visitors had only been in contact with the family for a short period of time (between 2–6 weeks).

10.2.3 Long term extra health visiting support

Long term extra health visiting can be classified as either (i) intermittent, or (ii) regular and intensive. Intermittent support tended to centre on families with a child with special needs (including children suffering marked developmental delay, chronic health needs or learning difficulties). In these cases health visitors made a judgement to maintain extra contact with the family, being available and ready to respond as needs arose, keeping an eye on family stability, but often adopting a fairly peripheral role. While several needs may result from the child's special needs, in only one case (3.53.3), were there additional family problems of a very different nature, where the child's father was terminally ill. One mother describes the nature of the extra support she has received:

> *There's been times when I've just felt really down, and frightened because I have got a handicapped child, not being able to get away from it, and I just feel dreadful and she'll say, "right, I'm on my way" ... I do feel very comfortable with* [HV], *and I see her more as a friend, as someone to liaise with ... and I can sit and talk to* [HV] *quite freely and get very honest, feedback from her, I'm always very impressed with her suggestions on how to deal with things. I'm able to call her at any time ...* (C 1.39.5:10-11)

Where intermittent support is offered to families with children with special needs, the family is largely in control but may require assistance as particular needs arise or parents come to terms with their child's difficulties. One health visitor described the long-term health visiting support often required by parents of special needs children and how this support alters over time as needs change and/or other professionals become involved:

> *With families with children with special needs you often need to give them quite a bit of support around the time the child is diagnosed, ... but once they get into the system and are actually offered extra services and so on, which obviously takes a while – then other health professionals to some extent take over the care and support of this family and you can withdraw to some extent ...* (HV 1.15.1:435)

In situations where long term extra health visiting support was frequent and intensive due to the presence of multiple needs, family problems tended to be either long-standing, or needs would continually surface.

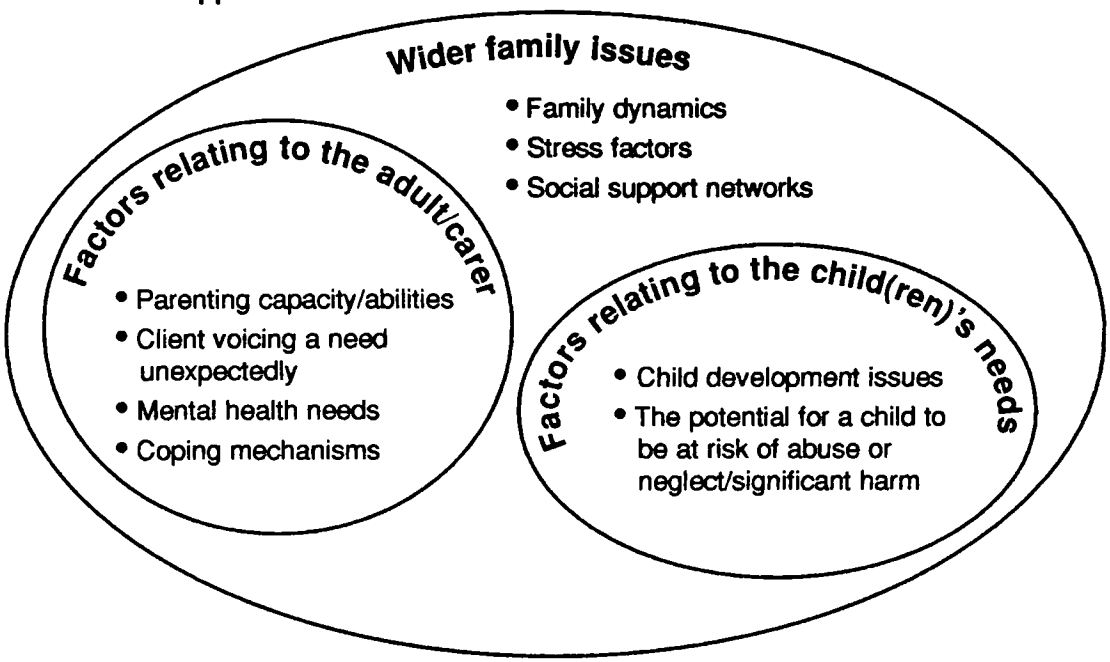
Interestingly, some clients appeared to have a recurring need for short term extra input. In such cases, as one need was met, another arose. In the case of client 1.15.4, an anxious elderly primigravidae, the health visitor described how needs have continually been raised – "*mothering wasn't quite what she expected*" (HV 1.15.4:17). Initially the mother didn't feel she was going to be able to cope with the baby and had concerns around the baby's weight gain and feeding. When these expressed needs were met, issues around colic and eczema arose and at the time of the study the baby had a sleep problem.

The requirement for extra health visiting was often a transient state, with clients varying in their need for increased support depending upon particular stress factors and coping abilities at a particular time. With the exception of those clients who appeared to have a recurring need for short term extra input, most of the families receiving this type of long term support, were families where concerns are 'multi-factorial' and family situations 'chaotic 'or unstable.

10.3 The range of needs and significant factors in offering a family extra support

During initial interviews the researcher explored with practitioners the factors they would draw on in forming a professional judgement that a family needs extra support. The process of assessment is individual to each practitioner as described earlier in Chapter 9 and there was a view that because of the individuality of health visitors there could well be diversity about what constitutes a need for extra health visiting. However, while describing health visiting assessment utilising the many skills/strategies highlighted in Chapters 8 and 9, there were certain features that the health visitors regarded as particularly significant in their assessments of families needing extra support and about which there was general consensus (See Figure 10.2).

Figure 10.2: The range of needs and significant factors for offering a family extra support



These broadly encompass the three inter-related dimensions identified by the Dept of Health (2000) and included:

10.3.1 Factors relating to the adult/carer

Parenting capacity/abilities

Health visitors would consider how the client(s) are managing parenting, including their insights into and expectations of parenting, their abilities to provide basic care for their child(ren) and how well satisfied are the child(ren)'s emotional and physical needs. They were also concerned with levels of interaction between parents and child(ren), their apparent relationship and degree of bonding. Health visitors would assess the way parents:

> *actually hold the child, the way they speak about them and if I was there for feeding then quite often how they hold the baby while they're feeding is very important.* (HV 3.53:79-81)

Parenting capacity has been identified as one of the three critical aspects to be considered by professionals when making assessments of children in need. The Dept of Health (2000:20) has highlighted the importance of professional "*observation of interactions*" distinguishing the contribution of different parents where relevant and

considering how children are described by parents/carers. Indeed this focus on observing parent and child interaction including social stimulation and emotional warmth was particularly emphasised by health visitors in the study:

> *There's a lot of different ways that children behave, and that says a lot about the relationship between the mother and the child and I don't think that should be underestimated.* (HV 1.82:170)

Client voicing a need unexpectedly

Health visitors regarded it as extremely significant if a client calls them unexpectedly and voices a need. As illustrated in Chapter 8, health visitors would try and respond to such a call as soon as possible. Unplanned attendance by a client in clinic can also be indicative of a problem or need.

Mental health needs

Health visitors continually described their central role in assessing parental mental health needs and intervening where necessary. Many felt they had a key role to play in identifying clients with actual or potential depressive illness or in the case of new mothers, the possibility of post-natal depression. While parental mental illness "*does not necessarily have an adverse impact on a child*" (Dept. of Health, 1999b:9), it could result in the neglect of a child's physical, social and/or emotional needs. Research evidence indicates that where parental mental illness is linked with a history of parental self harm or attempted suicide, psychosis, previous hospitalisation, or a history of previous injury to a child, then this makes children especially vulnerable (Hawton et al, 1985; Falkov, 1996; Cleaver et al, 1998b; Reder and Duncan, 1999). Parental substance misuse may also result in mental behaviour or states where children are placed at increased risk (Hagell, 1998; Dept. of Health, 1999b; Reder and Duncan, 1999).

Coping mechanisms

The assessment of parental coping skills was highlighted by many health visitors as a significant factor in determining a family's ability to cope with stress factors and ultimately their need for extra health visiting. As previous research findings have

indicated (Appleton, 1993) the analysis suggests that the degree to which a family is affected by stressors is dependent upon two factors, firstly how the family is able to cope with the stress and secondly the levels of support which a family has access to. Health visitors stressed how important it is to assess how parents are dealing with problems, taking in to account their individual coping mechanisms:

> *everybody deals with stresses in different ways and at different times you may be able to cope with a stress and then at another time you may not be able to. It just depends on what factors are working at that particular time.*
> (HV 2.91:37)

There was a recognition that parental physical and mental health is an important resource for coping with children and their demands (Cleaver et al, 1998b).

10.3.2 Factors relating to the child(ren)'s needs

Child development issues

Identifying a child's developmental needs is a central feature of health visiting assessment and practitioners would address physical health, growth and development, as well as the emotional and social aspects. A sound knowledge of child development in relation to the child's age and stage of growth is crucial for health visitors to be able to effectively assess each aspect of a child's progress (Dept. of Health, 2000). Developmental delay and child behavioural difficulties i.e. sleep problems, feeding difficulties and behavioural problems often result in an offer of extra family support.

The potential for a child to be at risk of abuse or neglect/significant harm

Many practitioners described the need to be alert to the potential for a child to be at risk of abuse or neglect. Research suggests that child safety depends primarily on three factors "*the adequacy of parental supervision, the physical care of the child and the safety of the home*" (Cleaver et al, 1998b:16).

10.3.3 Wider family issues

Family dynamics

Many health visitors felt that general family dynamics, particularly family relationships and any difficulties, as well as communication and interaction between parents, could

be a significant factor in determining a family's need for extra health visiting, especially when there is evidence of violent relationships (Dept. of Health, 2000). Health visitors repeatedly described the importance of observing parental interactions and the way parents address their children. Health visitors were constantly on the watch for tensions between parents and their reactions to each other. This sometimes included relationships with other relatives or friends living in, or visiting the family home. Cleaver et al. (1998b;1999) have suggested that children are less likely to be negatively affected by parental difficulties when problems are not associated with family violence, when they are mild and short in duration and do not lead to family breakdown.

Stress factors

Stress factors impacting on the client or family such as attempted suicide, bereavement, unemployment and financial hardship were also deemed significant. Some health visitors also identified stresses that may impact families from the wider community or neighbourhood. This was particularly noticeable in two of the case sites. In site B where isolation from living on huge estates was a problem for many families as one mother described:

> *...it's just got no atmosphere, nobody talks, nobody wants to know you ... I just feel as though I'm stuck in this house all the time...* (C 2.38.1:292)

In site C, deprived and hostile neighbourhoods, break-ins and the threat of violence were commonplace and often caused considerable family stress.

Social support networks

In making a professional judgement about a need for extra support health visitors would go to considerable lengths to assess the existing social support networks that a client or family has access to and their degree of social isolation. Many women participating in the study were single parents and in such cases health visitors seemed acutely aware of the demands that parenting can make on these women.

Social support appeared to reflect the following six dimensions:

- Immediate family support from a partner
- Extended family support from parents, siblings and other relatives
- Social support from friends in the neighbourhood
- Professional support – Health Visiting
- Professional support – Primary Health Care Team
- Professional support – Involvement of other agencies and organisations.

Health visitors talked about assessing the immediate family support available to a mother from her partner, whether or not he is able to offer support and help. They would assess whether extended family such as parents or other relatives were living close by, particularly if a mother has no current partner. Practitioners would explore how well a mother gets on with her extended family and the extent to which she could draw on them for help. This was often the case when identifying the help available to new mothers:

> *I find normally if somebody's going to be depressed or very stressed or maybe their relationship goes through a bad patch following the birth of the baby, if they've got some support nearby then I can - I feel like I sometimes give them permission to say you know "phone your mum up and ask her if she can have the baby for a couple of hours while you get your head down and get some rest", otherwise they feel they have to go on and keep going.*
> (HV 1.39:235-237)

If a client has no immediate family support in the area, health visitors would often explore if social support was available from friends or neighbours, in that they would try and establish if there was somebody close by that a mother could call on or somebody who might be available to baby-sit:

> *If there aren't any relatives I usually try to put her in touch with someone in a similar situation where they can get just support - peer support really.*
> (HV 1.70:143-145)

Professional support was available to some parents, including direct support from the health visitor. One health visitor described it as follows:

> *Family support is to do with acknowledging that ... they* [the parents] *have skills and I'm not the bringer of all skills and all information. ...* [I] *try to be a reassuring, encouraging presence.* (HV 3.49.1:81-89)

Often health visitors would endeavour to put mothers in contact with others in their local area to try to overcome problems of isolation and establish supportive networks. Clients valued this type of input. Direct support offered by the health visitor might involve "*just being there*", caring, listening to the client and offering advice as appropriate. This may be the only support that a client has access to as people are increasingly removed from relatives with little backup. It was interesting to note as Edwards and Popay (1994) have previously described, that some health visitors seemed to denigrate the value of listening and support, often not recognising their inherent value. There was also a widespread belief that with current service cutbacks and resource constraints the extent of such health visiting support is often fairly limited.

In some cases professional support was available from the wider primary health care team and might include a first time mother's support group or parenting programme. Professional support might also be available to a client if they refer themselves or are referred by a practitioner to another agency or organisation. However, as Hupcey (1998:314) has noted "*before social support is provided, the provider must perceive a need in the recipient and must be motivated to take the appropriate action.*" Lack of resources for families with increased needs was continually raised as a problem.

Most health visitors seemed acutely aware of the problems of social isolation for clients and their families. Many regarded lack of support as the final straw that could precipitate client vulnerability and an inability to cope with their particular circumstances.

10.4 The range of client and family needs

The families participating in the study and in receipt of 'extra health visiting' had a wide range of different needs, each unique in their character and presentation. (See Appendix 10.1 for a brief summary of the range of needs presented by clients/families). It is important to point out that health visitors identified a range and combination of factors that they would draw on in determining that a family needed increased support. Indeed the health visitors referred to 87 separate factors. (See Appendix 10.2 for a summary of the factors considered by the health visitors when determining a family's need for increased support. The factors considered pertinent at

both the initial and current contact are included.) The table presented in this appendix does not aim to provide a quantification of the factors considered by health visitors, rather it intends to illustrate the pattern and range of factors existing in the data. It is interesting to note that many of the concern factors raised by health visitors in the initial interviews were present in the range of needs existing in families involved in the study. Presumably when interviewed, these needs were in the front of practitioners' minds because of the current families they were dealing with.

As Cowley et al. (2000b) have found needs varied in their nature and complexity and ranged from those that were short term and easily dealt with, such as a first time mother experiencing an initial breast feeding difficulty, to those family situations where needs were more complex. An example of the latter is given in the following extract in which a health visitor summarises her concerns about a family she has known since the birth of the first child 2 1/2 years previously. She regards the family as extremely vulnerable with multiple problems, mother's self care is poor and father has been in prison for drug dealing, the youngest child is being cared for by grandparents and the care of the oldest child is "*casual*":

> *I felt we were on the edge of a child protection issue and also that mother herself is... her life is going the wrong way... Her mother said she used to be really well organised, clean and reliable. She said of all her children she couldn't have believed that* [Mother] *would go this way ... she's living dangerously. She's not on any contraception, she doesn't have any periods, and she hardly eats. It's possible she's still on drugs, she's got debts, and she's not seeing her child. I mean you don't have to be terribly perceptive to get worried about* [Mother] *and how she'll manage* [2 1/2 year old child] *... her shortage of patience, her availableness to the child, her lifestyle, the business or whatever it is she's doing takes priority and I even think if we get that place in the nursery which I have managed to, I even think she might not take her...*
>
> (HV 3.49.4:109-111)

10.5 The changing nature of client need

It was often not difficult for a health visitor to make a professional judgement that a client needed extra support. Often clients had immediate needs that were easily identified, but in many cases it would take the health visitor a longer period of time to uncover the full range, depth and complexity of needs. In some cases a health visitor

would help to address one problem and then another need would be raised by the client or be uncovered, thus enabling another need, subsequently identified, to be dealt with.

In virtually all the visits (48) where this was not a single one-off contact, clients' needs and some of the factors that a health visitor took into account in offering a family extra support had changed since the initial contact. This adds further weight to the principle described in Chapter 8 of the on-going nature of assessment. It also reflects the skilled 'know how' required of health visitors to work with clients to elicit their health needs, and the central role that a trusting relationship has in this process. Figure 10.3 offers a case illustration of the on-going nature of health visiting support and how needs change over a period of time. Significantly it provides an illustration of the progression of events, the time taken for needs to emerge and the nature of the extra support offered by HV 2.06.2 in response to this mother's needs.

In many family situations needs emerged over time. As Figure 10.3 illustrates needs were either raised by the client or were identified, or uncovered by the health visitor over a 6 month period. This may well relate to the health visitor getting to know the family better and the client feeling more comfortable in raising issues with her. De La Cuesta (1994b:453) has described the client relationship as "*an enabling mechanism*" yet highlighted how the efforts involved in building such relationships tend to be taken for granted. Furthermore, as Bergen et al. (1996a) and Cowley et al. (2000b) have identified, needs assessment is an on-going and continuous activity.

Figure10.3: An illustration of needs changing over time with client 2.06.2

Time period	Health visitor assessment key issues	Client perspective	Type of needs
August	HV making comparisons against expected norm All OK – but HV had 'slight niggle'. This 'feeling' based on behavioural cues Client young and living alone with 16 month old child Bit of vulnerability and insecurity about mum	**Move to new area** Child's hearing needed to be reviewed	Child's hearing to be reviewed No other needs evident
September **October** **November**	Building up relationship with client Practice nurse identified mother's vulnerability	Building up relationship with Health Visitor	Ongoing need
December (early)	HV not surprised about client's 'needs' Intensive work with client and a range of support given Listening Talking through options	Contacted HV with boyfriend problems. Disclosed history of physical and emotional abuse by stepfather. History of abuse in family. Client had felt suicidal. Had financial problems. Nobody to share problems with and coping with 16 month old alone	Current needs raised by client and needs uncovered by HV
December (middle)	Short term goals set with client: 1. Go to CAB to sort out finances 2. Talk to paternal grandparents for support with 16 month old 3. Arrange regular contact with 16 month old and ex-partner	Client initially unable to address needs/short term goals Client found HV easy to talk to on phone so able to open up with her	Client unable to address needs
January		Started to address needs and work toward short term goals	Beginning to deal with situation and address needs
February	**Reduce increased support to client**	**Addressed goals** **Planned house move to new area/fresh start with new partner**	**Needs addressed**

10.6 Types of needs

The activity of searching out and raising awareness of health needs is a central feature of health visiting practice (CETHV, 1997; Twinn and Cowley, 1992). Indeed as Chalmers (1993) found there are a number of different types of needs, associated with different contexts, which may be uncovered at different times and which stimulate alternative responses from the professional and client. In a taxonomy of needs assessment, Cowley et al. (2000b:130) also refer to the "*depths*" of needs assessment distinguishing between "*superficial or 'easily seen' needs; ... deep-seated; ... hidden ... or unacknowledged needs.*"

In the current study as part of the process of judgement formation, health visitors reported undertaking a needs assessment. Several different types of needs were identified, however, it is important to note that the term 'need' is used here in a generic way. Indeed need is a term used frequently in all aspects of health and social care (Thayer, 1973; Buchan et al, 1990; Orr, 1992; Billings and Cowley, 1995). The literature reveals that many professionals have written about needs from their own perspectives, for example the sociological view of need is illustrated through Bradshaw's (1972) taxonomy of social need in which he describes normative, felt, expressed and comparative needs. Need is also a term used commonly in the field of psychological theories of motivation, while health economists have attempted to distinguish between the concepts of need, supply and demand (Stevens and Gabbay, 1991; Ham, 1999). There is general consensus in the community nursing literature that need is not fixed, but subject to a variety of interpretations and influences (Cowley and Appleton, 2000). As such it is often regarded as a contested concept (Buchan et al, 1990; Stevens and Gabbay, 1991; Billings and Cowley, 1995), "relative" in nature and largely dependent on individual value judgements (Buchan et al, 1990; Orr, 1992:112).

The needs uncovered in this study included :-

10.6.1 Urgent needs

An immediate response was required to address the problem or difficulty. For example, a health visitor had visited a young mother with an 18/12 toddler and found that her boyfriend, a drug addict had discharged himself from rehabilitation, had started thieving again and then turned up on her doorstep with his face slashed after being chased by drug dealers who were demanding repayments. During the visit she was able to help raise the mother's awareness about the potential risks of this situation "*the uncertainty, the unpredictability of it*" (HV 2.06.1:82), the possibility of the dealers turning up at her flat and potentially threatening her and her child. This mother had been so worried about her ex-partner she had failed to realise that he was putting them at risk, until the health visitor addressed this with her. They then explored ways of protecting herself in her home, talking about security and contacting the police. Because of the urgency and potential danger of this situation they discussed mother's need to move, with her child to a safer place and the mother decided to move temporarily to a relative's house.

10.6.2 Ongoing current need/s

This relates to those needs previously identified by the health visitor and client and is on going, for example, in the case of client 1.39.4 the on-going public health/environmental problems caused by pigeon excrement.

10.6.3 New need expressed by client

In some situations clients would identify and open up discussion about their needs. Several clients in the study had contacted the health visitor either expressing a need, or requesting help. In many situations clients want to address this need. In the case of visit 1.15.4 the parents had talked about their 10-month-old's sleep problems with the health visitor in clinic and asked for some help. They requested a home visit to discuss the sleep problem further and following the health visitor's advice introduced a structured behaviour modification plan. In other situations, the client may not wish, or may not be able to address their expressed need at the present time. One young client whose grandfather had died unexpectedly less than a fortnight earlier, was unable to begin grieving properly as she was concentrating on supporting her grandmother at the funeral.

10.6.4 Health visitor identifies a new need/needs during a client contact.

This may be either (i) obvious or (ii) uncovered or disclosed during the contact. Chalmers (1993:902) has described the former as "*easily seen*" needs. It reflects those needs that are clearly apparent to the professional, such as physical health problems e.g. a baby's nappy rash caused by thrush. Chalmers (1993:902) describes the second process as one of "*opening up the need*". For example, during one visit HV 2.77.3 was able to uncover and explore a mother's fears that her child might die during major heart surgery, she described how important it was to respond to this client's cues and demonstrated considerable skill during the encounter:

> *I was aware that it was going to come before I went because when I'd seen her in the health centre, it was there. She was always on the verge of tears. There's something she's always wanting to say but it's never the appropriate time ... if it hadn't come then, it had to come sooner or later. I had to force the issue - because - she's talked about his death and what she would do and how she would think, but not exactly how she would cope with it ...*
> (HV 2.77.3:85)

There were situations when a client did not recognise a need that was evident to the health visitor or even if they did recognise it, they did not wish, or were unable to address it at that time. Health visitors recognised that change may not always be possible and this relates to the skill of using their professional judgement to 'gauge' situations as described in Chapter 9.

Sometimes health visitors identified a need that they did not share with the client. This again appears to link to the strategy of 'gauging' the client situation. A minority also described making judgements not to raise sensitive issues with clients so as not to compromise their role with families. In one situation HV 1.82 described her concerns about the children's poor state of cleanliness in a large family, but as it was not interfering with their socialisation did not address it with the mother because she desperately did not want to upset her. Her rationale being that "*while I'm accepted there that it's possible for me to have some influence*" (HV 1.82.3:134). Indeed the client continued to accept this health visitor because she was not directive or authoritarian.

10.6.5 Potential future needs/risks

In several situations potential future needs/risks were identified and raised by the health visitor or client. These needs were identified through the range of situational factors/presenting problems. Following one home contact HV 1.15.3 was very concerned about the potential risk of a serious accident, because of the mother's lack of awareness of the dangerous activities of her $2^1/2$ year old. During the visit the toddler attempted to play with plug sockets, pulled on stereo wires and climbed the rungs of a chair back, while his mother remained apparently oblivious to these dangers.

10.6.6 Unmet/undiscovered needs

In a small number of cases health visitors indicated that there were likely to be unmet or undiscovered needs, which they were unable to put their finger on. These were recognised by the health visitor alone and based on external cues or health visitor 'feelings'. They appear similar to the "*suspected hidden needs*" described by Chalmers (1993:902). In one case, HV 2.06.1 determines from her observations of and cues from a young mother's behaviour, that her phobia about sleeping in her bedroom may be linked to her previous rape.

10.7 Extra health visiting – the client perspective

The evidence presented in Chapters 6, 7, 8 and 9 endorses the view that the majority of health visitors in this study rely on their professional judgements in deciding to offer clients extra support rather than formal guidelines. Yet it also seems appropriate to consider to what extent clients are involved in that judgement particularly in view of the increasing interest in client involvement in practitioner decision making (Entwistle et al, 1998) and secondly, to examine client views about the effectiveness of health visitor interventions in addressing their needs.

First it seemed pertinent to present a description of clients' understanding and expectations of the health visitor role.

10.7.1 Client understanding of the health visitor role

Parents' understanding of the health visitor role was largely dependent on their own experiences, combined with preconceived ideas partly informed by others. Only a

quarter of the clients knew that health visitors have a nursing (and some thought midwifery) or health care background, yet it was interesting to find that a large proportion still reported seeking health advice from these professionals. One mother with three young children (1.39.3) and another (1.82.3) with four were astonished to discover that health visitors initially trained as nurses. Furthermore, in Site C only one of the 15 clients interviewed knew their health visitor had a nursing background. What seemed clear from the data was the fact that few health visitors had attempted to explain their role fully, resulting in a general lack of understanding amongst clients about health visitors' background and training.

While the majority of parents drew on their own experiences to inform their understanding about the role, many were still unclear about the purpose of health visiting. Views were mixed about the central focus of the health visitor role. Client views were broadly equally split about whether the focus of the role centred on mothers and children, children alone or the whole family.

10.7.2 Expectations of the health visiting service

The majority of clients regarded health visitors in a positive light, particularly highlighting their role in helping parents to bring up children and providing practical support. Where health visitors were viewed negatively, clients either viewed them as ineffective and unable to offer them any help or found it hard to trust their health visitor, as in the case of one mother who had been referred to social services by her previous health visitor without her knowledge. It was important for clients to feel that their health visitors treated them with respect and as an equal. One mother describes:

> *She doesn't treat me as I'm, as if I'm ignorant, or - erm, common, or, you know, like useless or anything, ... I feel that she treats me as an equal. She doesn't see me as, well she's like, she's authority and I'm a mother, it's, we're two women having a chat, and she's helping me.* (C 2.06.3:149-153)

A small number of clients had been rather wary before having any exposure to the service, as the following quote reveals:

> *I felt ooh I'm not sure if I like this, they're going to be poking their nose into all our business and asking how me and* [husband] *get on and all this sort of things and I was wary, I felt well they just poke their nose in but it's completely different she's just been so nice, so helpful.* (C 2.38.4:7-10)

Clients had preconceived ideas about health visitors. Some were worried about health visitors' impressions of themselves and their lifestyles. However many parents soon came to realise that these worries were unfounded as they began to get to know their health visitor better. Indeed Pearson (1991) found in a study exploring clients' perceptions of health visiting, that parents' perceptions of the service changed over a period of contact.

When clients had had no previous experience of health visitors the perspectives of close relatives or friends often influenced their views. Over a quarter had heard negative tales of health visitors and general dissatisfaction with the service. One mother suggested that clients may perceive health visitors badly if "*they just haven't managed to ..spend the time and get to know their health visitors the way I have...*" (C 1.39.5:103). Some clients had heard that health visitors were "*interfering busybodies ... critical rather than helpful*" (C 2.06.3:59-61) and "*just straight nosey*" (C 3.71.4:102).

Old wives tales persisted, with some clients initially worried about health visitors checking on cleanliness, until the health visitors negated this view. One client commented:

> *..and because it's called a 'health visitor' I remember at first feeling nervous and I thought that they come to visit and see if your house is clean...* (C 1.39.1:189)

The literature also suggests that health visiting has been tarnished with having a policing role (McIntosh, 1986; Mayall and Foster, 1989). In contrast, in the current study only a minority of clients perceived health visitors as having a checking and

inspection role. Yet some parents did describe an initial worry that health visitors might be in a position to remove a child from the home:

> *from what I've spoke to the girls, I think they all think that the health visitor's some big bad person that's going to tell them they're doing it all wrong and that their kids should be taken off them or something. It's just a frightening figure of authority at first until you realise - and I didn't realise the health visitor was going to be like this at all.* (C 2.77.1:130-131)

While such stereotypical views clearly persist they were soon dispelled by parents' first hand experiences of health visitors, as Machen (1996) found. Furthermore on the whole clients did not view health visiting and social work roles similarly as other research has suggested.

It was interesting to find that while a minority of clients (5) reported having had a good relationship with their previous health visitor, 14 had had a poor relationship, yet they had not been put off the service. Arguably their current health visitors had been extremely successful in overcoming such negative experiences and as Machen (1996) and Twinn (2000) describe it is likely that the health visitor's personal attributes were a key to this process.

Despite some clients having negative experiences, only one client felt that she did not want a health visitor at all, despite describing her as seeming to be "*a nice lady*". This mother really felt that she did not need a health visitor, she had a history of puerperal psychosis and was worried that professionals regarded her as unfit because of her past history; sadly this mother was terrified about her children being taken away from her.

10.7.3 Are clients aware they are receiving extra health visiting

It was pleasing to find that a large proportion of the clients were aware at the time of the study that they were receiving extra support. A small proportion implied that they were aware of this fact although not stating so directly. Some commented on the

frequency of visits "*I was seeing* [HV] *nearly every day at some point...*" (C 2.20.1:37), while others recognised that they had been involved in local schemes associated with extra health visiting:

> *Well both mine have been on the CONI scheme which means I have to have regular contact particularly in the first year with a health visitor.* (C 2.20.3:76-78)

Others compared their current experience of increased support with earlier encounters with the health visiting service.

10.8 Covert activity or skilled professional judgement

Data indicated that not all health visitors always verbalise explicitly a professional judgement that they are offering a client extra support or why this might be the case. The notion of "*giving extra support*" may rarely be clearly stated by practitioners, instead a certain tacit understanding appears to exist between health visitors and their clients. This implicit understanding may exist because of health visitors' skills in being accepted and allowed to work with clients around their health needs. This view is further supported by the fact that the client information sheet clearly referred to the fact that the study was about 'families receiving extra health visiting support' and that no clients questioned this issue.

Despite the current NHS focus on partnership working between professionals and clients (Dept. of Health, 1997), health visitors would sometimes adopt what could be broadly described as covert practices when gaining access to some clients. Nine health visitors reported or were observed to engage in this type of activity. It was displayed in the data in three different ways:

- Client is unaware of the extra health visiting input
- Finding an acceptable reason for visiting
- A double agenda - Client is unaware of the full nature of, and/or extent of the extra health visiting.

10.8.1 Client unaware of the extra health visiting input

Of the 8 clients who did not know that they were receiving extra health visiting, two (C 1.15.3 and C 3.53.3) firmly believed that they were not getting any help from their health visitor. One client C 2.38.3, felt at the time of the study that the health visiting service was unnecessary as she was receiving visits from the Community Paediatric team for her premature baby's feeding difficulties and oxygen deficiency.

Three clients (2.20.3, 2.91.3 and 3.53.2) who knew that they had received extra support in the past, did not perceive that they were currently receiving extra health visiting. Interestingly, these were families that the health visitors had described as having on going, long term needs. All had had previous social services involvement and at some stage their child(ren) had been on the Child Protection Register. While health visitors might be criticised for possibly 'monitoring' these family situations, the history of these families indicated that needs had continually emerged over the years, and that the health visitors' focus was on the safety of the child(ren). Health visiting interventions centred on establishing good working relationships with these families in order to be able to intervene effectively as needs arose (Dept. of Health, 2000).

10.8.2 Finding an acceptable reason for visiting

While health visitors largely adopted a policy of openness and honesty with their clients, it was evident that some health visitors occasionally adopted mildly covert strategies in order to gain access to client homes. Some health visitors appear to offer clients a pretext for going to visit, in that they would offer the client a more 'plausible' or more 'acceptable reason' for visiting. Sometimes the objective shared with the client would not be the sole reason for visiting. Such half-truths were used as a subtle and more acceptable way of gaining access to the client's home, in order to explore issues around health needs face to face with a client. Rather than this being a deliberately underhand strategy, this approach seemed to be used by the health visitors because of their awareness of the potential for clients to feel stigmatised by the 'extra service'. Therefore they would try and find an acceptable way of offering a client a home visit. Unfortunately such practices may help to perpetuate clients' lack of understanding about the focus of the health visitor role.

Health visitors felt that this approach is likely to have come about because of the reduced core visiting programme, as well as parents being more informed about core services. In all cases however the need to offer a pretext for visiting was based on a practitioner's judgement about the individual client situations:

> [It] *all comes down to judgement again doesn't it as to how much you say.*
> (HV 1.15:175)

Data suggested that health visitors may vary their approach and tailor their practice to individual clients and their particular needs, sometimes being open and upfront with clients and at other times using a pretext for contact.

10.8.3 A double agenda - Client unaware of the full nature of, and/or extent of the extra health visiting

While some clients knew they were getting extra input from their health visitor, they were not always fully aware of the extent of the health visitors' reasoning for this. For example, while client 1.70.1 was aware that her health visitor was offering extra visits to weigh and monitor the growth and development of her triplets, she was apparently unaware that her health visitor was concerned about her own lack of warmth towards her babies and how she was bonding with them. Indeed the health visitor commented that she wanted to be sure that she was not missing a case of post-natal depression and admits that it is likely that this mother did not know that she was the focus of the extra health visiting, yet justifies adopting this covert strategy:

> *I think having small children to look after is a tremendous, tremendously new experience and can be quite unsettling and I think a lot of mothers especially older mothers, they, from my own experience often feel that they must do everything possible for their children and they can never do enough, so a lot of mothers feel a lot of guilt when they don't give their children enough of themselves. I don't think it helps if you're necessarily open and say you know I can't think that it does, that it will do the mother any good to say are you bonding with your child really ... I certainly don't think it's fair initially to say this unless they bring it up themselves.*
> (HV1.70.1:135)

The offer of and implementation of extra health visiting seems to be something that the health visitors tended not to draw attention to. In another case, where a young

mother was living alone with her baby, the client 2.38.2 knew that she was getting extra health visiting because of her baby's prematurity and recent apnoeic episodes. However she was unaware that the health visitor also felt that she needed to offer this mother extra support because of her anxiety and under confidence. Another health visitor describes how she tries to go out of her way not to let mothers feel stigmatised by this targeted approach to extra health visiting, by not labouring the issue:

> *They know they're getting extra support ... they know it's a kind of negotiation, they know that I work like that and they often say to me "my sister isn't getting this, why isn't my sister ever seeing anybody?". So they know I'm extra I suppose, but I don't know if they know that, I-I put myself out for them not to feel stigmatised, so maybe that could minimise their awareness of getting extra support.*(HV 3.49.4:403)

Health visitors continually appeared not to overemphasise to a parent that they were offering them an 'extra' service. Arguably this tentative approach may be more acceptable to some clients and could be a strategy increasingly adopted by health visitors as a result of limited core programmes, where home visiting has become the exception rather than the norm. Some health visitors describe adopting this tentative approach if they need to go back to reassess a situation or had a gut feeling that they needed to follow something up.

It was also interesting that while a few clients seemed aware that they were getting extra support they were not always sure why. One mother, C 2.20.2 who had difficulty dealing with her daughter's behaviour has received regular monthly visits from her health visitor, but seemed unsure about whether this was the norm. A minority of health visitors also supported this view that clients may not know what to expect in terms of home visiting and the core service. This seemed to be particularly the case when families with long-term needs were transferred from one health visitor to another and had continued to receive fairly intensive input. As one practitioner stated:

> *they may not have realised that that was extra because I know that previous health visitors have also given them extra support so ...* [Mum] *... may have thought that this is ordinary health visiting and not outside the kind of sort of core programme.* (HV 1.82.2:159)

Practitioners commented that clients might not always be aware that they are receiving extra health visiting, because they offer support in a very general way.

Some health visitors appear to have "*a double agenda*" (HV 2.91.2:131) with some clients, in that health visitors would be open about part of the reason for making contact with a client, yet an element would remain hidden. For example, in the case of a young mother who was separated from her husband who had left her and their children to pursue a homosexual affair, the health visitor had offered the mother considerable emotional support. She had identified and helped the mother to talk about her anorexia and enabled her to seek help from a counsellor. The mother has now set up home with her new boyfriend. During an observed visit the health visitor had undertaken the son's 18/12 developmental assessment, and because of a delay in the child's speech said that she would contact them again in three months. However, later she admitted:

> *maybe if it had been another client, I would have said "I will be in touch with you when he or she is two", but because this is a new situation for her, I just want to make sure that she is coping.* (HV 2.91.2:127)

She describes the "*double agenda*" as:

> *It's a subtle way isn't it, rather than coming out to the person and saying, you know - in this particular instance well - you know - you've entered into another quite stressful situation here. I want to make sure that you're OK and that things are going smoothly* ... (HV 2.91.2:327)

Having another reason to make contact enables her to check out her concerns without raising them directly with the client, avoiding any needless anxiety.

Health visitor 2.77 states that sometimes she has a reason for visiting the family which is overtly discussed with them, but that also there may be more important underlying reasons for visiting, which remain hidden from the client. In one family situation, she highlighted the need to display an acceptable front to the parents in order to continue to be allowed access to the children, when she had underlying concerns about their potential neglect "*you've got to do it in a nice way*" (HV 2.77:245). Indeed this health

visitor appears to be describing a covert process of monitoring. Another practitioner, HV 3.53, tries to combine an extra contact visit with another reason for visiting, such as a child's developmental assessment that might be due. The latter is given as the reason for the visit but she will raise other issues during the home visit.

By not being truly open with clients about the fact that they are receiving extra health visiting, health visitors might be criticised for participating in covert activity, however this argument is largely diluted by the fact that most clients were aware that they were getting extra input. Critics might describe this as covert activity, but perhaps it is more about health visitors using skilled professional judgement in making the service as acceptable as possible and not necessarily underhand in its intention. This is similar to Chalmers' (1992) notion of health visitors presenting issues as 'normal' rather than 'deviant', in order to render health visiting acceptable and to help parents with the problems they were experiencing. Arguably, the whole notion of 'extra' is problematic, in that is presupposes that there is a recognised norm – a requirement that is fixed and static, which is clearly at odds with earlier findings about the nature of health needs.

10.9 The context for extra health visiting

Extra health visiting was generally offered in the home, with HV (1.15:420) describing how it was "*fairly unusual*" for her to be seeing a client outside a clinic session at her base site. Extra health visiting might be offered through support groups for new parents run in clinics or health centres, with this being particularly the case in Site B. However in Site C, all the health visitors viewed extra health visiting as home centred.

There was a widely held view that clients are more relaxed in their own home and are more likely to raise worries about their health needs. Health visitors felt able to make a more accurate and thorough assessment in a client's home:

> *... they're much more relaxed, they're much more honest with you. It's meeting them on their own territory really and it gives them privacy and also at home you're in a better position to observe how parents and child interact, and also it gives you the chance to see their own home environment as well.* (HV 1.70:451-455)

Others suggested that being in the client's own home altered the power base of the relationship in the client's favour:

> *It's far easier to be less of an expert and more of a somebody who is exploring ideas together with a mother, with a contribution of information adjusting it to where she is, ... the home visits have a better chance of being more of a partnership and you're also less likely to disempower...* (HV 3.49:384)

Most accompanied visits (52) took place in the client's home, with the remainder taking place at a friend or relative's house. Health visitors clearly felt that clinic environments are not conducive to the detailed exploration of health needs. However, many pointed out that they are doing less home visiting now and more clinic/health centre based work.

While a minority of participants had no preference as to where they would rather see their health visitor, the majority preferred home visits. Many described these as more private and personal, less stressful and not like being on "*a conveyor belt*" as many felt in the clinic/health centre. Clients described being more comfortable and at ease in their own home and generally felt that the health visitor could give them more time to have a proper discussion.

As other studies have reported (Sefi and Grice, 1994; Plastow, 2000) parents often felt inhibited and/or frustrated when contacting health visitors in clinics. Participants were particularly concerned about lack of privacy:

> *... I mean obviously they're probably not listening because they're not interested but it's just the thought of you don't want to tell her if you've got any problems you know in front of other mothers.* (C 3.49.1:214)

With such constraints it is unlikely that clients will feel comfortable in raising personal health issues. Some felt restricted in terms of the time available to them in busy clinics, with long waiting times or set appointments. Parents continually raised concerns about their children misbehaving and as a result they cannot relax and/or

found it hard to concentrate. One client with two youngsters described clinic visits as "*a nightmare*" (C 2.91.3:438), while another said:

> *sometimes if kids are performin' in clinic an' that' you just can't wait to gerr out.* (C 3.53.2:246)

A small number of women with children with special needs felt particularly perturbed and intimidated, as one described:

> *I don't like going to the health centre on a Thursday while all the other ladies are there with their kids and they're all being weighed - I don't like that situation at all. I mean...In fact, I hate it. ... It's the inconvenience of it I hate it. ... I'm an individual and* [child - 11 months] *to me is an individual ... there's a lot of kids down there. There isn't any children like* [child - 11/12] *who have a disability and I just feel because she has that disability I want attention straight away off them and I don't get it so I get frustrated when I go down there and often I'll just walk out. I hate it.* (C 2.77.1:172-187)

A minority of clients had also had negative experiences of different health visitors at clinics, which supported the view of them wanting continuity from the same health visitor.

10.10 Extra Health Visiting Support - Client Perceptions

The majority of clients interviewed valued the support and interventions offered to them by their health visitor and most found practitioners facilitative in helping them to address their needs. Data analysis indicated five categories relating to clients' experiences of health visiting which participants regarded as effective strategies in enabling them to identify and address their health needs:

- Being there and active listening
- Enabling - offering reassurance and/or reinforcement
- Practical help
- Offering information and advice
- Referral and liaison.

10.10.1 Being there and active listening

Many parents described instances of "*if you've got a problem*" the importance of being able to contact and talk to their health visitor when they needed them and of the health visitor listening to their concerns. It was evident during home visits that health visitors continually provided this type of support as Edwards and Popay (1994) have previously described. However, while one practitioner worried that just talking things through with a client may not be 'proper' health visiting, most regarded this as a central part of their role:

> *I feel I'm just being there for her. Somebody to talk to, somebody to cry to because I feel that is important and that's therapeutic.* (HV 1.25.1:162)

The need to talk was repeatedly raised by clients:

> *she's been a great help to me 'as* [HV] *... and in all five kids I've had they've always been there for me. You know there's always someone to ring and a helping hand at the end of the telephone...* (C 3.53.3:16)

'Being there' and 'listening' were recurrent themes in the data. One mother commented it's having the knowledge that her health visitor is around and that even if she is busy knowing that she will always phone her back and will listen to her.

The ability of the health visitor to be a good listener was continually raised by clients. Clients described many instances when their health visitor had listened to their problems and then offered helpful advice, ideas and support or perhaps referred them elsewhere for help. The central importance of health visitors' developing skills in active listening has been highlighted in previous research (Edwards and Popay, 1994; Twinn, 2000), although Kendall (1993a) has suggested that health visitors may not find this aspect of their role easy. Certainly when health visitors did not appear to listen to clients or blocked cues, this resulted in the interaction becoming less free flowing and quite stilted. As Bryans (1998) has reported it tended to result in the client engaging less freely in conversation or responding negatively or in monosyllabic fashion.

Clients valued health visitors demonstrating their interest, by remembering a previous conversation or by giving them an opportunity to talk about their concerns. When, as reported by one mother, her previous health visitor came "*carrying the burdens of other people's problems*" (C 1.39.5:21) this resulted in her not wanting to access the service. Making time for clients and focussing solely on their needs was regarded as an important quality.

Support from the client perspective was clearly linked with practitioners being available. Those health visitors who adopted an open door policy and were easily accessible were regarded as very supportive. Clients wanted to feel they could contact their health visitor at any time without being made to feel that they were being a nuisance. Over a third preferred to contact their health visitor rather than GP for health advice, as they were concerned about being perceived as "*neurotic*" or "*not coping*". One mother suffering from post-natal depression after the birth of her third child had been told by her GP that she "*was too sensible to be depressed*" so had contacted her health visitor instead:

> *she was very helpful because I just didn't know where else to turn to at that time ... she just let me talk and have a cry and she said that I could go in and talk to her anytime about any problems that I was having she was just really nice, which is what I needed, someone to be sympathetic and not say that I was too sensible to be depressed.* (C 1.82.4:24-28)

Trust was a central issue, as Cowley (1991) has previously identified, with clients describing the importance of confidential and private discussions. Trusting a professional was essential to building up an effective working relationship. Many clients regarded their health visitor as a friend, rather than an 'official' or 'authority' figure, this viewpoint emerged time and time again in the data:

> *I've got confidence in her. I can talk to 'er 'cause she does seem more like a friend than somebody official knockin' ont' door.* (C 3.53.2:143)

Furthermore six clients referred to their health visitor as a mother figure or "*it's like having a chat with mum*" (C 2.06.3:546) appearing to regard them as a role model.

Four of these women were older and more experienced mothers, yet still valued the need for a certain type of maternal support and a caring/listening ear.

Clients wanted health visitors to be caring and supportive. Many described examples of health visitors being "*tremendously supportive*" (C 2.77.2:180), helping them to cope with the demands of parenting or supporting them through relationship problems. For some, they had no one else to turn to, isolated because of personal circumstances from friends or family.

Clients felt that it was extremely important for health visitors to be able to put them at ease, making them feel comfortable, so that they could talk honestly and openly. One father described how he and his partner have grown to trust their health visitor over the years and are not frightened to say "*we're just not coping at the moment as well as we'd like to...*" (C 2.20.4:476). He said:

> *We've always felt that you know she's always understood because she's a parent herself, ... and it's alright to cry and it's alright to get down and wish sometimes that the kids would just disappear, you know, but she's never, never made us feel with anything, with the kids that we've been bad parents, you know.* (C 2.20.4:483-485)

This couple described how their health visitor picks up on their cues and opens up discussion with them around their needs.

While active listening is regarded highly by many clients, there were some examples in the data sets where "*just listening*" or "*we just talk*" and "*they're just there*" were viewed much less favourably by clients. Indeed during seven visits where listening and talking predominated, these activities did not appear to be supportive interventions for the clients involved. One client (C 2.38.3) felt that she did not need a health visitor at the present time as she was getting extra support from the community paediatric team, while three others (C 1.15.3, C 1.70.4 and C 2.20.2) felt they did not need the service, regarding it as largely intrusive. In three other situations (O 1.25.1, O 3.53.1, O 3.53.3) it appeared that the clients regarded the service purely as a way of getting help with material items or finances, thus they wanted practical help.

Yet in another three visits (O1.39.4, O1.82.3, O3.53.4) where from the observer's perspective and also their own, the health visitors appeared to be "*just listening*", being there but undertaking few other interventions, the clients found the visits extremely therapeutic and helpful in addressing their needs. This would seem to suggest that clients' requirements of the service do vary. Furthermore while it might be expected that health visitors adopt similar approaches with all their clients, the data suggested that this was not the case and that some health visitors would adopt different styles and approaches with different clients. (See Appendix 10.3. for a case example). Indeed while some visits were clearly highly facilitative a minority appeared largely ineffective, with health visitors adopting a passive stance that was unhelpful for clients.

10.10.2 Enabling – offering reassurance and/or reinforcement

De La Cuesta (1994b:453) previously described the health visitor-client relationship as an "*enabling mechanism*" to help health visitors "*to know the client and family, to gain and maintain access to the home and to produce reciprocity*". In this study however, the enabling function of the relationship centred on health visitors giving clients the confidence to feel comfortable in their parenting. Positive reinforcement has previously been described in 9.9.9 as a simultaneous assessment intervention strategy used by heath visitors to reinforce clients' progress. As Machen (1996) and Plastow (2000) also found, clients emphasised the importance of receiving reassurance and encouragement and this was a strategy that many practitioners adopted in practice.

Clients who had been offered reassurance from their health visitor believed this had helped them to deal with their problems. It was especially valued by first time parents who often found it exceedingly stressful caring for a new baby and sometimes felt undermined by societal expectations of parenthood. Many expressed fears about becoming a parent and valued the help and reassurance that they had received from their health visitors.

Most clients valued having access to a professional who they regarded as having expertise in child health and development. They appreciated being offered reassurance and acknowledged that while learning the ropes as parents health visitors can "*put your mind at rest*" (C 2.20.4:29). Yet they also wanted to talk to someone who would acknowledge their own abilities and would not be critical of their parenting:

> *She's been very supportive. She doesn't criticise. She says that mums seem to know what's best for their children, which is nice, not somebody to preach at me rather just support me basically in what I'm doing.* (C .2.77.3:13-15)

During many accompanied visits health visitors were observed to engage in this type of enabling activity and while there was some evidence of the authoritarian and directive approach found in earlier studies (Sefi, 1985; McIntosh, 1986; Mayall and Foster, 1989; Kendall, 1993a, 1993b) this tended to be less evident within the data. Clients found it particularly helpful when health visitors reinforced that what they were doing was right and supported them in their chosen options. A large proportion felt encouraged by practitioners who adopted this type of non-directive but very facilitative approach:

> *Well she's like, like my safety net, if I've not felt very confident about doing something with* [baby - 9 weeks], *she's been there to help me with the advice ... she's like my strength, if I'm feeling weak, emotionally weak, she's sort of there to push me on, ... she brings the confidence out in me, she'll say to me, "well you did the right thing there, you know", and that will make me think, oh I'm right, and I'll be pleased that I did the right thing... she's given me the strength to make the decisions on my own.... she's guided me to them, but I've made the decisions, she hasn't made the decision for me, so that's made me get my confidence.* (C 2.06.3:455-461)

With less support available from extended family networks many parents relied on health visitors' feedback and reassurance. One mother whose partner walked out and left her with two under fives said "*she would always listen and she's always got a shoulder to cry on*" (C 3.07.4:311), while another (C 2.77.3) valued the supportive and encouraging cuddles her health visitor had given her when she had been feeling particularly low. Nearly half of the clients commented on the value of having

someone who was a neutral professional, not a family member, who they can talk to in confidence and who will legitimise their concerns.

The legitimation of client concerns was particularly evident when health visitors had reassured clients that it was all right to be worried or to express their needs or feelings. It seemed that they were giving parents permission to state that they were feeling this way. One mother described:

> *I mean I half turned around and said to her "look am I being paranoid?" and she's never once said yes. And she said to me "do you feel paranoid?" And I says "well I don't know". And she says – "Well I don't think you are. I would be worried if it was mine. Even Dr.* [GP] *doesn't think you're being paranoid." And she's always listened to what I've got to say. And no matter how trivial I maybe think it is, she'd never made it seem trivial. She's never trivialised anything and she's never made you feel as though she was pooh poohing outside or never had time ...* (C 3.07.4:178-182)

The outcome of this type of support was often a boosting and an increase in a client's confidence and self-esteem.

10.10.3 Practical help

Clients liked health visitors to offer practical suggestions for parenting, perhaps carrying out a hands on task and showing a parent how to wind their baby. One mother described:

> *I didn't have a clue what to do. I mean even when I'd had him, I mean I'd given birth to him and I didn't know how to change a nappy or anything and I do think that first time parents do need the extra help.* (C 3.49.1:148-149)

Many clients gave examples of how health visitors had offered them practical help. This included writing letters to housing departments, supporting clients in their applications to charities for financial aid, helping with written applications for childcare, taking and accompanying clients to hospital appointments, picking up their prescriptions and passing on baby clothes/toys.

Some practitioners appeared to be 'doing extra' and going beyond the call of duty, which was highly valued by their clients. For instance, one had lent a pregnant mother

a slow cooker when she had moved into her flat and had no cooking facilities, two practitioners had taken labouring mothers to hospital and another had lent a client money for a termination. One mother who was destitute with a new baby had had a Moses basket and baby clothes organised by her health visitor:

she got me absolutely everything I needed for a baby... (C 2.20.1:89)

This mother was extremely grateful for the help she had received and seemed to repay her gratitude by ensuring she gave toys/clothes which her own children had outgrown to her health visitor to pass on to other mothers. This reciprocal exchange process has been highlighted in the literature (Chalmers and Luker, 1991; Chalmers, 1992), with De la Cuesta (1994b:454) describing health visitors "*offering extra services to clients*" to "*effect obligation*" and gain compliance from clients.

Practical assistance took many different forms. In one family where the father was on remand and the student social worker had not known how to make progress, HV 1.25.1 had liaised with the Home Office and family solicitor to try to sort out finances for the family, after they had been refused benefits. Often health visitors were the sole professional supporting families in need, so inevitably role boundaries merge. Health visitors perceived that this was particularly so in the case of social services, where departments are overstretched and staff under enormous stress. This seemed to substantiate De la Cuesta's (1993) findings that described health visitors engaging in "*fringe work*" when they are "*confronted with gaps in resources or services they attempt to respond to them by filling or bridging them*" (De La Cuesta, 1992:193). Nettleton (1991) terms it "*assuming responsibilities for others*" and also describes health visitors being forced into a social work role, which he terms "*social work by proxy*". Clearly if health visitors are bridging the gap between health visiting and social work it creates enormous role conflicts, as Taylor and Tilley (1989) have previously identified.

A small number of health visitors also believed that families continue to prefer input from health visitors rather than social workers – "*parents are frightened to death of social services still*" (HV 2.77:338). While this view hints at the professional rivalry identified by Dingwall et al. (1983) and Taylor and Tilley (1990), it was also borne out

by a third of the clients who felt more comfortable and less threatened when working with health visitors than social workers, who they largely found not very helpful.

10.10.4 Offering information and advice

There was a consensus of opinion amongst the clients that they had received helpful advice from their health visitors. Many perceived this to be a central part of the health visitor's role as Machen (1996) and Twinn (2000) also found. Parents reported receiving advice on a range of issues including feeding, general childcare, managing behavioural difficulties and minor ailment management. Some had received helpful advice on dealing with relationship difficulties and advice on their rights as women. First time parents often regarded health visitors as their only source of advice. One young mother (C 2.38.4) with a five-week-old baby described how she would have abandoned breast-feeding if was not for the advice, perseverance, reassuring support and back up of her health visitor.

Some first time parents were frightened of leaving hospital with a new baby, often feeling isolated, with no one to contact if things go wrong. This young mother talks about how overwhelming she found motherhood:

> *I dunno when I had* [child - 16 months] *I never thought I could cope with a baby. At first I had no idea what the hell was going on and she* [HV] *really helped me. She's so nice - I couldn't have coped* ... (C 1.39.1:23)

While Twinn (2000) found many clients describing examples of negative advice giving, only a minority of clients in the current study described this problem. When difficulties did arise, they emanated from contradictory or repetitious advice giving, advice not working, a critical or uninvited approach or the client just not remembering the advice. The former appeared to be a problem when staff in hospital and the community gave clients conflicting advice. However, one mother was particularly critical of "*the standard response to problems*" (C 1.70.4:178) she had received from her health visitor "*let's just cover what we've covered ten times before and we'll go away and we still haven't resolved anything.*" (C 1.70.4:137). This client felt health visitors needed to be more highly trained in specialist areas i.e. crying babies, breast feeding problems.

On the whole parents valued the advice health visitors offered them and rather than presenting a picture of unwanted or inappropriate advice giving as Heritage and Sefi (1992) found, many seemed happy to question advice if they felt it was inappropriate and make their own mind up about accepting advice. Although, as Twinn (2000) previously found a number of clients did not just want advice to enable them to make their own decisions, they actually wanted to be told what to do:

> *I needed someone to tell me that I was right – this is how it's done or that's not right or – because I didn't know what to- you don't know what to do. It's really weird I mean everyone thinks that with mothers – it comes natural to them. It doesn't. I still don't understand things about her. I just don't ....* (C 1.39.1:210).

It seems that having someone to provide advice takes some of the weight off the client's shoulders and enables a sharing of concerns and responsibility. Generally there was a sense of empowerment in term of advice giving, with practitioners often encouraging clients to make their own decisions about their needs or enabling them to sort out their own solutions.

10.10.5 Referral and liaison

There was a strong indication that many clients regarded referral and liaison as an important part of the health visiting role, with health visitors referring clients for a range of services. As one pointed out:

> *If you've got a problem they can refer you or they can tell you where to go, it's been extremely helpful.* (C 1.15.2:38)

When a child with a gastroscopy tube transferred-in to Area A the health visitor played an important liaison role, ensuring mother was linked up with a local dietician, and also making referrals to speech therapy and to the child development team and Family Centre. In this case the health visitor stated "*I really needed to get him into the system ..., as soon as possible*" (HV 1.25.2:86-88), which she regarded as essential when limited resources are increasingly stretched. Another health visitor in Site A described how "*the waiting list is getting horrendous now*" (HV 1.15.2:63) for special needs children to be assessed by the Child Development Team, which

indicates the importance of early detection and referral. Indeed a recent study has highlighted the significance of health visitor referrals in the discovery of pre-school children with pervasive developmental disorders (Hyman et al, 2001).

The data suggests that health visitors' referral function may have increased in importance as clients have to wait longer for GP appointments. An interesting feature was that in several cases health visitors appeared to assist clients to 'work the system' by speeding up appointments or referral processes. This was evident when HV1.15.1 was able to bring forward an appointment by 3 months for parents to see a Consultant Paediatrician with concerns about their daughter's condition. Other examples included helping clients to change GP, following-up late or missing hospital appointments, speeding up initial assessments at specialist clinics, making appointments and fitting children in quickly to be seen by their GPs. This ability to move clients through the system swiftly was described by one mother when the health visitor enabled her child to be seen by the GP without an appointment:

> *I stripped him off I said "what's that on his bum?" and she says "that's thrush girl". She said "don't panic" she said "I'll get you straight into the doctor don't worry" she said...* (C 2.20.1:413)

In some cases health visitors liaised directly with other health professionals or agencies on the client's behalf. One mother who was bleeding following a D and C was feeling very low but didn't feel able to express this to her GP. Her health visitor was able to intervene on her behalf:

> *I was feeling really unhappy, and, you know, before I knew it, she'd had a word with the doctor on my behalf, because I didn't feel I could go to him, ... she rang me up, and said I've spoken to* [GP], *and when I went in the next day, I didn't have to tell him how I was feeling, because I didn't want to... I didn't want to get upset there... So she's helped me, you know, there because I wasn't, couldn't have done it on my own. I couldn't have.* (C 2.06.3:121-127)

In such cases parents' feelings of self-consciousness may be considerably underestimated by health professionals.

10.11 Summary

To conclude this chapter has explored the nature of extra health visiting support from both the health visitors' and clients' perspectives. It began by presenting a conceptualisation of the continuum of extra heath visiting which highlights the dynamic and variable nature of this concept. Health visitors identified several factors relating to the adult/carer, the child(ren)'s needs and wider family issues which they regarded as particularly significant in their assessments of families needing extra support. The analysis suggests that there are different degrees of extra health visiting which appear to relate to a professional's judgement about families' current needs, their support mechanisms and coping abilities. Realistically extra health visiting will also vary in its extent and nature depending on resource availability in primary care and the time constraints and demands of an individual health visitor's caseload.

The families participating in the study and in receipt of 'extra health visiting' had a wide range of different needs, each unique in their character and presentation. Data indicated that not all health visitors explicitly verbalise a professional judgement that they are offering a client extra support, although most clients seemed aware of this fact. This again reiterates the study's new discovery that assessment and intervention are not always separable. The latter part of the chapter moves on to examine clients' perceptions about the effectiveness of health visitor interventions in identifying and addressing their health needs. It describes a number of strategies relating to clients' experiences of health visiting which participants regarded as particularly helpful in enabling them to identify and address their health needs.

10.12 Overview of the Main Study Findings

In summary, a deliberate intention of the main study design was to select three case sites where contrasting guidelines were issued to health visitors to assist in the identification of families in need. This strategy has enabled a detailed examination of health visitor professional judgement, as well as an exploration of the impact of formal guidelines on health visitor practice. In Chapter 6 health visitors' perceptions about the adequacy of local guidelines for identifying family health need across the three case study sites was examined. Despite an NHS ethos of guideline formulation, an apparent contradiction to guideline development lies in their limited use in practice. A feature of the analysis was

the fact that even when guidelines exist, most health visitors use their own professional judgement in making family assessments.

In view of the apparent importance of professional judgement in needs assessment, Chapter 7 moved on to explore health visitors' constructions of professional judgement in more detail. While highlighting the overall complexity of professional judgement, the chapter attempted to explicate some of the central features of this concept. The health visitors described professional judgement in terms of both a process activity and an outcome or product. The chapter presented a visual conceptualisation of health visitor professional judgement and its relationship to assessment, which set the scene for a more detailed exploration of health visitor assessment processes in chapters eight and nine. The judgement process appears to incorporate a sophisticated process of needs assessment, influenced by a range of knowledge and experiences.

Chapters 8 and 9 attempted to explicate the various elements associated with the processes of identifying and assessing family health needs. Indeed they endeavoured to unravel some of the complexity of health visiting assessment processes. The analysis suggested that the health visiting assessment process is a complex, interactive and serial activity, with health visitors co-ordinating information from a variety of sources in order to assess health needs and formulate professional judgements.

There appear to be certain fundamental elements associated with the majority of health visitor assessments and these have been termed assessment principles. These features are central to health visiting assessment and continually appeared within the data, they were explored in detail in Chapter 8. The assessment principles and their attributes reflect the basic principles of health visiting assessment practice, which exist despite the constraints and realities of the practice context and can be differentiated from the activity centred methods of the assessment process.

Chapter 9 presented a discussion about the seven key elements including their sub-categories that constitute the activity centred methods of the health visiting assessment process. A key finding of the analysis was the integration of some health visitor intervention activities with assessment processes. Finally Chapter 10 returned to the concept of 'extra health visiting support', exploring this concept from both health visitors' and clients' perspectives.

Chapter 11

Final Discussion

11.1 Introduction

In this thesis health visitors' use of professional judgement and formal guidelines in identifying health needs and prioritising families requiring extra health visiting support has been examined. This final chapter will critically analyse the study's contribution to the theoretical knowledge base of the discipline of health visiting. It will begin by outlining how knowledge gained from a concept analysis of professional judgement and preliminary research work informed the development of the main research study. A summary of the key findings of the study will be presented using the principles of health visiting (CETHV, 1977) as a robust framework. This will facilitate a critical discussion of the new knowledge that has emerged from the study and a consideration of the implications and potential use of the findings for health visiting education, practice and management. Finally the study's limitations are examined and recommendations made for future health visiting research.

11.2 Key issues emerging from the literature and concept analysis

Chapter 1 argued that child health promotion work forms the basis for assessment and targeted work with children and families in need. This chapter briefly outlined the particular methods and approaches used by health visitors to identify children and families requiring extra health visiting. These include risk assessment screening, the use of guidelines, such as caseload weighting and health visitor professional judgement. Two issues appeared important and emerged from this brief introduction. Firstly, the extent to which assessment guidelines and visiting protocols direct health visitors in

making assessments of family health needs. Secondly, the nature and value of health visitors' own professional judgements and factors that influence those judgements.

In view of the potential importance of health visitor professional judgement in the assessment of family health need, Chapter 2 explored the concept of professional judgement, using Morse's (1995) method of advanced concept analysis. This concept analysis revealed the interrelated nature of the concepts of professional judgement, clinical reasoning, clinical judgement and decision making. These concepts are often used interchangeably in the literature and the analysis attempted to explicate the differences and commonalities between them. Discussion also centred on the complexity of knowledge and its relationship to professional judgement. The analysis explored ways of knowing that are likely to influence health visiting practice. However, it is notable that while nursing knowledge has been examined by many nurse theorists and researchers; with the exception of Robinson (1982) and Goding and Cain (1999), few attempts have been made to explore the nature of health visiting knowledge per se.

Two broad theoretical approaches for studying the concepts of judgement, clinical reasoning and decision are found in the literature, these are the rationalist and the phenomenological/interpretive perspectives. While an extensive body of theoretical and empirical literature exists in this area, in relation to acute hospital medical and nursing care, health visiting literature is sparse. Although the health visiting literature has many references to professional judgement and decision making there is little evidence of detailed theoretical or empirical analysis. Indeed exploration of the concept of professional judgement in health visiting is largely undeveloped and there is a paucity of health visiting research in this area. In the only study focussing purely on health visitor decision making, it is interesting to find Lemmer et al. (1998) indicating that clinical practice guidelines influence health visitor decision making. Yet no review of the impact of such guidelines on judgement processes had taken place.

A further theme emerging from the review is that rational approaches to decision making research seem inappropriate for the study of health visiting practice, where

the central focus of the work is not about the discovery of diagnoses but on family centred, health promotion work, often involving long term assessment. Health visiting practice is influenced by a large number of constantly changing variables that cannot be effectively examined through rational theories of decision-making. It would seem more appropriate to examine the complexity of health visitor professional judgement by adopting an interpretive perspective. Chapter 2 concluded by highlighting that there have been no studies specifically investigating the nature of professional judgement or the processes by which professional judgements are made in either health visiting or the wider community nursing field.

11.3 The preliminary research work

In view of the current NHS impetus on developing clinical guidelines to improve standards of client care, it seemed highly pertinent to undertake a preliminary study to establish a national picture of the existence of clinical practice guidelines for the identification of children and families requiring extra health visiting support. A postal survey of the Senior Nurses of all Community Trusts (179) in England employing health visiting staff was conducted. The survey had two purposes. Firstly, to gather information about the existence of clinical guidelines to assist health visitors in identifying and prioritising families needing extra health visiting support. This was important as there was no existing literature in this area. Secondly, copies of local Trust guidelines were requested from each Senior Nurse and the intention was to examine the documents in order to evaluate their validity and reliability.

11.4 Key findings of the preliminary study – a critical discussion

The exploratory questionnaire resulted in a response rate of 87% (156 Senior Nurses). The findings of this preliminary work provided new evidence that clinical guidelines are widely available in 98 (63.2%) Community Trusts in England to assist health visitors in identifying and prioritising families needing increased health visiting support. Sixty-seven (68.37%) areas sent a copy of the practice guidelines to the researcher, with 77 separate guidelines being sent in total.

A rigorous process of documentary analysis was conducted (Appleton and Cowley, 1997) which provided useful insights into the types of guidelines issued to health visitors. Many of the guidelines were presented as formal protocols and quite significantly, there was a lack of uniformity between them. Guidelines included checklists, scoring systems and screening tools, vulnerability standards, lists of risk indices, family health assessment tools and aide memoires for risk assessment. It was found that some guidelines might not assist practitioners to assess family health needs at all, for example, dependency scoring criteria where families needs are classified on a continuum of dependency. Yet this sort of classification can only take place once a practitioner has made a professional judgement that a family is vulnerable. They do not help to explicate the assessment process at all.

The fact that no standardised guideline is used throughout the country is significant and may reflect ambiguity surrounding family vulnerability. It could also exacerbate the difficulties which health visitors face in articulating how they make family assessments. The majority of documents – 35 (45.45%) were classified as checklists, scoring systems and screening tools, which appeared to be heavily influenced by the scoring approaches of non-health visitors used in screening risk assessment in child abuse. The study provided evidence that there appears to be a strong link between child protection and respondents perceptions about guidelines to assist health visitors in assessing families requiring extra support.

Each guideline was critically examined to determine evidence of validity and reliability. There was a lack of structured assessment formats, which could reduce the risk of user bias and many of the risk indices contained in the guidelines were fairly subjective and not well defined. Many of the guidelines included risk factors in some form. When all the various risk factors were collated there were 133 different types mentioned in the documents, many of which are not supported by sound research evidence. These findings support the argument presented in Chapter 1 that the predictability of risk assessment instruments is not sufficiently high for them to be regarded as reliable tools (Cleaver et al, 1998a), that risks and needs change over time (Elkan et al, 2001) and must be frequently reviewed (Hagell, 1998).

The majority 54 (79.41 %) of the 68 guidelines which included risk indices in some form gave equal weighting to all risk indices. Furthermore the content of a number of guidelines indicated a lack of recognition that family vulnerability could be the result of multiple interacting factors, with some guidelines focusing solely on one aspect, such as the child's needs. The research evidence underpinning the development of the guidelines was minimal. The fact that many of the documents sent were not based on systematic research evidence raises the question of whether they should be regarded as 'clinical practice guidelines' of the kind described by The Nuffield Institute for Health (1994) and Grimshaw and Russell (1993). It was proposed that 'formal guideline' is a more accurate term to describe many of these documents.

Overall the guidelines provided little evidence of validity or reliability. This has implications for managers and practitioners who persist in developing 'vulnerability' guidelines. In reality people have all sorts of problems and coping skills, but identifying a screening tool or guideline which accurately identifies when that turns into a need for professional help seems an impracticable task. Of the areas with no official guidelines, eleven reported to be in the process of developing them. It is worrying that many Trusts were considering the inclusion of such guidelines in service contracts when the majority appear to lack rigor. It also raises questions about why managers insist on the development of such guidelines, and yet this view is rarely challenged.

Despite the wide variation in clinical guidelines, findings indicated that 53 (68.83 %) guidelines recognised the importance of professional judgement to some extent. This raised a number of pertinent questions:

- Does the use of checklists and guidelines constrain professional judgement?
- To what extent do assessment guidelines and visiting protocols direct health visitors in making assessments of family health needs?
- Do health visitors make their own clinical assessments of families needing extra support or do they have a checklist at the back of their mind or a guideline to refer to?

Furthermore 57 (36.8%) Community Trusts had no clinical guidelines to assist health visitors in identifying families needing extra support indicating that in these areas practitioners relied on their own professional judgements when making family assessments. This finding, supported by that of an earlier study, where health visitors reported relying on their own professional judgement in identifying families needing input despite the presence of official guidelines (Appleton, 1993; 1995), provided further justification for the need to examine professional judgement in health visiting. The paucity of relevant literature (Chapter 2) offered further evidence of the need to elucidate the components of health visitor professional judgement.

11.5 The Main Study

The main study sought to examine health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support. A case study strategy guided by a constructivist methodology was used to examine the concept of health visitor professional judgement. Insights from the preliminary research work influenced the sampling strategy and a deliberate intention of the study design was to select three Community Trust sites where contrasting guidelines were issued to health visitors to assist in the identification of vulnerable families. The focus of interest was to attempt to understand the factors that may influence a health visitor in making a judgement to offer a family extra support and to find out what the essence of that support might be. The study considered how formal guidelines and professional judgements contribute, if at all, to the process of targeting health needs. It was also concerned with examining client views about the effectiveness of health visitor interventions in identifying and addressing their health needs.

11.6 A Critical Discussion of the Main Study Findings

This critical discussion of the main study findings will use the principles of health visiting as a robust framework for relating theoretical issues to practice (CETHV, 1977). These principles provide a vehicle to consider the implications and significance of the study for health visiting education, practice and management. Interestingly, the principles have also been adopted in the recently published draft competence framework for health visiting (UKCC, 2001).

11.7 The Search for Health Needs

Despite the apparent determination of some health service commissioners to limit the scope of health visiting, the study findings reinforce the previously well-recognised and important role which health visitors have in identifying children in need and their families (Dept. of Health 1995). Health visitors have a wealth of knowledge and experiences of working in this area. While recent policy has attempted to distinguish between vulnerable children, those in need and children on the child protection register, health visitor participants were largely in agreement that extra health visiting equates to client contacts that are additional to those offered through the core child surveillance programme (Dept. of Health, 2000). Extra health visiting can relate to a single, one-off contact or conversely be intensive and on going. The existence of a continuum of extra health visiting support was evident (See Figure 10.1) and highlights the dynamic nature of this concept. This has important implications for practice, emphasising the need for practitioners and managers to reassess vulnerable populations at regular intervals.

A classification of the 'extra health visiting' offered to clients in this study contributes to the knowledge base of health visiting practice, by attempting to explicate some of the detail associated with this important, but often neglected area of practice. Extra health visiting is not static, but shifting and variable and largely dependent on a practitioner's judgement about families' current needs, support mechanisms and coping abilities. However, a practitioner's ability to offer extra support may be limited by time and resource constraints and the needs of an individual caseload.

The main study provided revealing insights into the impact of formal guidelines on the search for health needs in the contexts under study. A feature of the analysis was the variety and range of guidelines existing across the three case sites for the identification of families needing extra support. This was particularly evident in study Site C, where even more surprisingly, none of the health visitors were aware of the formal guidelines that had been sent to the researcher during the preliminary study. While the implementation of guidelines may be desirable from an organisational perspective to facilitate workforce planning, to try and achieve consistency of

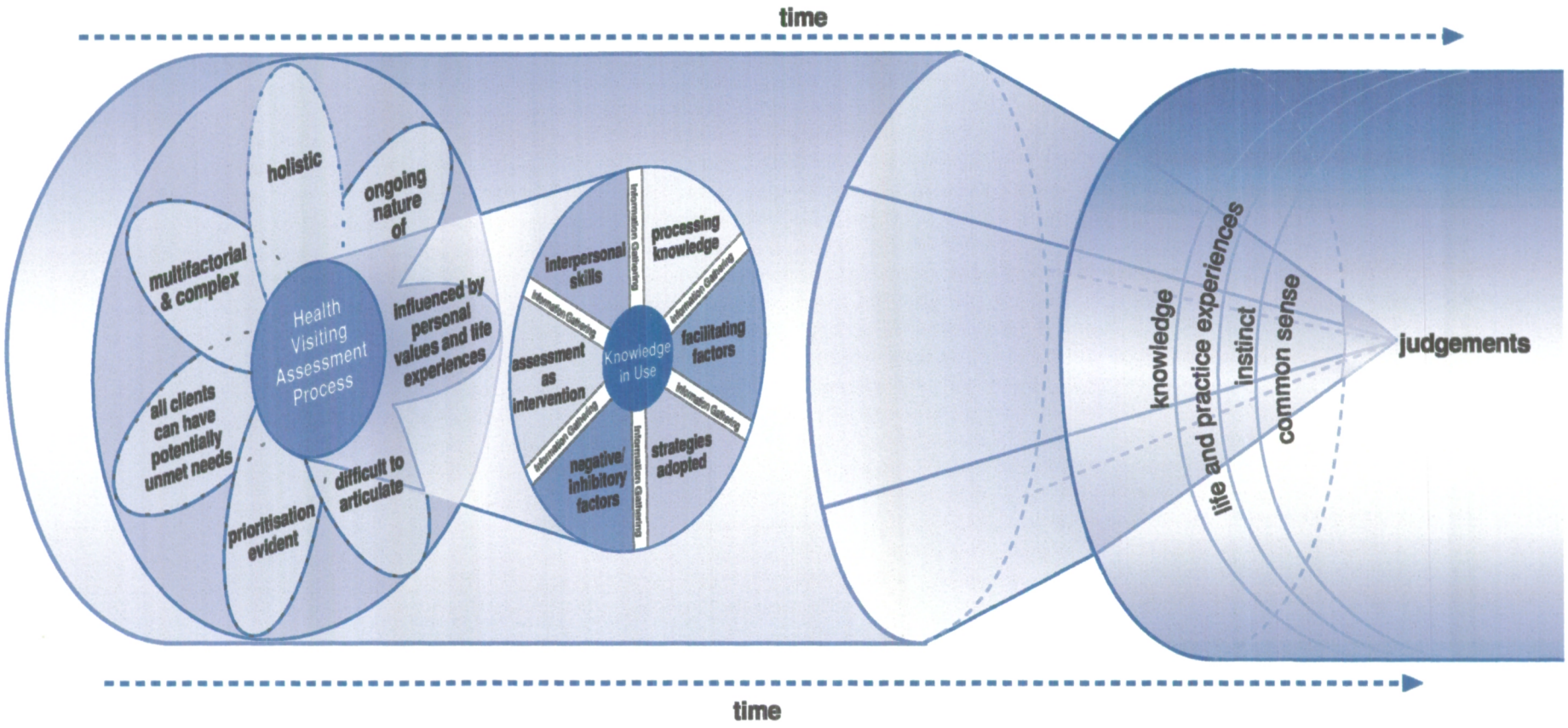
approach or perhaps enable purchasers to understand the range of therapeutic health visiting interventions, in practice this study has provided quite striking evidence to challenge this perspective.

Despite a culture of NHS guideline formulation (Dept. of Health, 1998b), an apparent contradiction to guideline development lies in their limited use in health visiting practice. While a minority of health visitors reported during initial interviews that guidelines may be helpful in enabling them to raise health issues with clients not routinely addressed, many found them awkward to use or difficult to integrate into a visit. Others were critical of guidelines for not necessarily addressing a family's immediate needs or the client agenda. Furthermore, despite the existence of guidelines in two case sites, in practice most health visitors were apparently using their own professional judgement in making family assessments. This was especially evident in Site B where health visitors were very clear that the Priority Index Guideline did not help in the assessment of families needing extra support. Instead in this site health visitors appear to make an assessment, prior to categorising need within the prioritisation framework. Therefore even when guidelines exist (as the documentary analysis revealed), no accurate predictions can be made about health visitors' actual knowledge of, or use of such guidelines in practice.

Interviews with health visitors provided insights into their constructions of professional judgement. Initially a number commented that it was quite difficult to articulate their understanding of professional judgement, because they are rarely asked to explain the meaning of this concept. However, in the current climate with health visiting increasingly at the centre of heated debates about its purpose (Gooch, 2001; Radcliffe, 2001), it is essential that health visitors can articulate the basis of their professional judgements if they are to market their services effectively.

The detailed constructions resulting from the inquiry contribute to the theoretical knowledge base of health visiting by explicating the notion of professional judgement and providing a visual conceptualisation of health visitor professional judgement and its relationship to assessment (See Figure 11.1). This theoretical model has been

Figure 11.1: A conceptualisation of health visitor professional judgement



developed from the findings of the study and offers a useful means of depicting the relationship between professional judgement and individual elements of the assessment process. It is hoped that this model will facilitate health visitors to demonstrate and articulate their practice more clearly to managers, other professionals and health service commissioners.

Health visitors described professional judgement as both a process activity and an outcome or product. The process of professional judgement reflects the way in which health visitors form and reach their professional opinions and incorporates a complex process of needs assessment, influenced by knowledge, clinical and life experiences and for some, instinct. Health visitors appear to draw on skills and knowledge from a wide range of experiences when making needs assessments and forming professional judgements. Health visitors are rarely asked to reflect on the judgement process. Instead in practice it is the outcome, the judgement, that is often the central focus.

Judgement outcome incorporated a view about the urgency with which a need must be dealt with thus encompassing an element of prioritisation. This prioritisation centred on whether the need actually existed or was a potential need, how it was being managed and the interventions or referrals needed to help deal with the need. An interesting feature of the findings, which supports Tanner's (1986) view is that rarely is judgement formation an isolated event, instead health visitors often make a series of judgements about a family situation.

Needs assessment is a central component of the process of forming a judgement. By integrating data from health visitor and client interviews combined with observations/recordings of health visitors' interactions with clients, the components of needs assessment have been scrutinised and new insights uncovered about the detailed elements of this process. The case study approach adopted in this study has been extremely productive as a means of unpacking the various elements of health visiting assessment. It is important that these components have been laid out for public scrutiny, rendering simple complex processes and providing insights into health visitors' practical 'know-how' (Schön, 1987).

Several key principles emerged through data analysis and appear central to health visiting assessment. These characteristics are integral to, and provide the basis upon which health visitors' assessments are conducted and professional judgement is formed. Some principles, such as the on-going nature of health visiting assessment, its general complexity and the influence on the process of personal values and experiences are already well documented in the literature. However, other elements, such as assessment, focussing on the whole client context, rather than a single problem or issue and the clear evidence of prioritisation are more new. These assessment principles and their attributes reflect the basic principles of health visiting assessment practice which exist despite the constraints and realities of the practice context and can be differentiated from the activity centred methods of the assessment process.

Seven key factors constituting assessment processes were identified :

- Interpersonal skills
- Potential knowledge base in use
- Processing knowledge to aid the assessment
- Facilitating factors
- Strategies adopted to aid the assessment.
- Assessment as intervention.
- Inhibitory factors.

These elements of assessment are extremely labyrinthine and involve health visitors adopting a range of skills. The analysis suggests that the health visiting assessment process is a complex interactive activity, with many processes inter-linking and occurring simultaneously, sometimes carried out so automatically that they were not always recognised by practitioners. Furthermore because of the individuality of health visitors each would place a slightly different emphasis on these various factors in relation to unique family situations. While it might be expected that health visitors adopt similar approaches with all their clients, the data suggested that this was not the case and that some health visitors would adopt different styles and approaches with different clients.

While Chalmers (1993) and Appleton (1995) have previously highlighted some of the skills and processes utilised within the search for health needs, this study by combining methods has provided more detailed insights into the complexity of these processes and further developed the theoretical knowledge base of health visiting assessment. Furthermore by seeking out the client perspective the study has revealed interesting insights about health visitor practices that may not legitimate client need.

The intricacies of needs assessment have important implications for health visitor education. A recognition of the complex processes associated with needs assessment could be incorporated into educational standards, which currently do not provide explicit detail about the skills and knowledge required in the identification and assessment of health needs (QAA – Academic and Practitioner Standards, 2001). Indeed these competency standards only require health visitors to "*utilise a range of assessment techniques*" (QAA, 2001:11) without explicating any detail. The study data could provide useful insights for the current UKCC (2001) consultation exercise examining standards for health visiting. As Cowley et al. (2000a) have stressed there is a need for a benchmark by which professional performance may be assessed.

The elements of assessment represent a unique combination of knowledge, principles, interpersonal skills and processes which could help to inform health visiting educational curricula. This seems important in the light of recent reports (Clark et al, 2000; Cowley et al, 2000a) which have identified marked differences in the length and content of health visitor education programmes, with some failing to address health visiting principles and assessment of need and not all reflecting UKCC (1998) standards. These researchers and Pearson et al. (2000) draw attention to the often substantial gaps between current policy, educational provision and the reality of practice.

In order to fulfil the principle the 'search for health needs' health visitors must have the opportunity to search out, identify and assess children in need and their families (Dingwall and Robinson, 1993). However, with many health visitors describing the effects of reduced home visiting services and very little time to actively 'search' out needs, it is likely that some families in need will not be recognised. Identifying

families in need is central to this principle of health visiting and the findings of this study have taken a step forward in opening up to scrutiny some of the processes involved. This was a gap highlighted in the literature in Chapter 2.

11.8 The stimulation of the awareness of health needs

The re-examination of the principles of health visiting highlighted the need to stimulate an awareness of health needs not only at the client level, but also at a management level and at a national level amongst policy-makers (Twin and Cowley, 1992). In the latter case the principle is being applied so that those responsible for providing services are aware of unmet needs. The shared responsibility for a population to be aware of its health needs has recently been addressed in health policy (Dept of Health, 1998a). The findings of this study provide clear evidence that health visitors across all three sites are identifying families with additional health and social needs who require additional input to the restrictive core programmes. Health visitors have a professional responsibility to impress on their managers the identification of these unmet needs. Conflicts exist when Trust managers and purchasers equate core programmes to the actual numbers of visits that families need and when such protocols are being used to ration services.

As previously argued in Chapter 1 the universal Child Health Promotion Programme (Hall, 1996) offers an important opportunity to undertake both child and family health needs assessments and to stimulate awareness of health needs through preventative interventions. At the individual level, an interesting feature of the analysis was that health visitors' assessment strategies were frequently intertwined with intervention activities directed at further clarifying or raising client awareness of health needs. While this finding supports those of Grobe et al. (1991) who found that in hospital nurses' clinical reasoning, patients problems and interventions were often considered together and Chalmers (1993) who described multiple processes occurring in unison, it does appear to take a step forward in explicating several intertwined assessment/intervention strategies adopted by the health visitors.

One of the most commonly intertwined assessment/intervention strategies adopted by health visitors involved raising clients' awareness about the health visiting assessment. This included a practical visible element often combined with the health visitor talking through her assessment with the client. Sometimes this intervention strategy would be combined with positive reinforcement about how well a client is doing or about a child's progress. Again this detailed explication of practice provides new knowledge which can usefully inform the theoretical basis of health visitor education for needs assessment practice. It also raises questions about how the stages of need assessment and health visitor interventions are taught (if they are taught), as distinct stages or combined processes.

The 'stimulation' of awareness of health needs implies a sharing of information between health visitor and client and an ownership on the part of parents. Yet the study findings revealed that health visitor professional judgements are not always shared with the client. The circumstances when health visitors share or not, appear on the whole to be to do with the judgement, rather than the health visitor or client. When health visitors made judgements that were not shared with the client, this appeared to be because the content of the judgement might have been perceived as threatening in some way to the client. It became apparent that there was a tendency for health visitors to share judgements with parents that focus on positive aspects and which are regarded as safe, non-threatening and acceptable to clients.

Exceptions to this finding, appeared to be when health visitors wished to convey to a client that they recognised the needs being faced by the client, in order to legitimise their feelings. In such cases health visitors seemed to carefully balance the degree to which a judgement was shared and this seemed to be influenced by the practitioner's degree of personal knowledge and familiarity with the client. In determining the extent to which clients were involved in the judgement to offer increased support, it is interesting to note that health visitors' professional judgements are not always shared with the client. Indeed judgements about client need or the potential need for continued support are often not openly addressed, yet in many cases there appeared to be an implicit understanding on the client's part they were receiving extra support.

11.9 The influence on policies affecting health

As previously described, the findings of this study indicate that a tremendous emphasis is still being placed on the development of guidelines for identifying children and their families requiring extra health visiting support, despite the fact that there is no solid research evidence base supporting their use. In fact the findings of the study lend great weight to such guidelines being insufficient. The continued use of such guidelines and visiting protocols has the very real potential to constrain professional practice and has implications for staffing levels and skill mix if used as a measure to allocate health visiting resources. Their use could further reduce the availability of an already overstretched health visiting service.

Few health visitors were involved in guideline development, which negates Grimshaw and Eccles' (1998) recommendation to involve potential users on the development group. In addition, despite the existence of formal guidelines, in practice most health visitors described using their own professional judgement in making family assessments. One explanation for health visitors not adopting guidelines in practice may be due to their lack of involvement in guideline development reflecting non-ownership of both the process and product. This raises the important issue of why health visitors do not exert influence on their organisations not to rely on such guidelines. Or at the very least as in Site B, where health visitors were very clear that the Priority Index Guideline did not actually help in their assessments of families needing extra support to raise management awareness of this fact. Health visitors may underestimate their potential to influence policies affecting health, despite representation on Primary Care Boards. Another explanation may be that practitioners are just so worn down by continual changes in primary care that there is little time to consider such radical action.

Furthermore in practice several contradictions and tensions exist for which the guidelines are a focus. One is the impact of core visiting protocols in providing a baseline for client contacts, with any contact above this being perceived by participants as an indicator of extra health visiting. Most health visitors regarded core visiting protocols as having been imposed on them by their employers, with no

consultation about whether these contacts were sufficient to assess and meet client needs. Without exception health visitors regarded the universal core programme as minimal provision.

One consequence of the core programme is that it can result in conflicts between a professional's judgement about a family's health needs and management demands for 'routine' service delivery. A further consequence is that health visitors may be unable to respond to, or identify needs early as they have very limited contact with most families. Such conflicts can mask the extent of workloads and as such are potentially disempowering to practitioners. Again, rather than challenging such local policies, health visitors appeared to adopt strategies to manage the core programme constraints, either by working to their own practice frameworks, as Chalmers (1992) has previously described or conspicuously ignoring the requirements of visiting protocols, instead focusing on supporting families with increased health needs. Unfortunately these idiosyncratic practices may perpetuate an organisational view that the core programme is satisfactory.

In practice health visitors strive to maintain a universal service. Indeed there is perhaps an assumption on the part of both employers and practitioners that a minimal service is better than none at all. Yet it can be argued that a paradox of this universality is that while a limited core service remains, health visitors are unable to fulfil their role properly. In practice health visitors were often unable to build up relationships with clients over a period of time, relying instead on the quality of the 'immediate relationship'. Several practitioners adopted a somewhat resigned view, commenting that there is often little time to get to know a family well enough for a client to feel able to seek out the service if needs arise. Indeed with such acute rationing there is likely to be a concomitant fall in level of consumer satisfaction. Cynically one could argue that this may be a deliberate management policy, for such service rationalisation resulting in widespread consumer dissatisfaction could result in its eventual disbandment.

11.10 The facilitation of health enhancing activities

Health policy must continue to recognise that health visitors have an important role to play in seeking out families with increased needs and that this is an essential prerequisite to facilitating health enhancing behaviour. A sensible and non-stigmatising strategy would be to support the continued provision of a universal health visiting service and regard all families as potentially in need of extra support at some point. As greater consumer involvement is advocated in the UK National Health Service by the Department of Health (Dept of Health, 1989; Dept. of Health, 1991; Dept. of Health, 1997; Dept. of Health, 1998b), this study took an important step forward in eliciting client views about the nature of increased family support to supplement observation and health visitor interview data. This enabled the identification of both positive actions that legitimate client need and negative ones, which do not.

The families participating in the study and in receipt of 'extra health visiting' had a wide range of different needs, each unique in their character and presentation. The majority of clients interviewed valued the support and interventions offered to them by their health visitor and most found practitioners facilitative in helping them to address their needs. Data analysis indicated five categories relating to clients' experiences of health visiting which participants regarded as effective strategies in enabling them to identify and address their health needs:

- Being there and active listening
- Enabling - offering reassurance and/or reinforcement
- Practical help
- Offering information and advice
- Referral and liaison.

In pursuing 'the facilitation of health enhancing activities' health visitors have traditionally acted as a resource for clients offering information about health issues, as well as providing a supportive service, building up parents' self-esteem and confidence levels. Clients clearly continue to value this function of health visiting. Twinn and Cowley (1992:28) highlight the many circumstances which may inhibit

health enhancing behaviour and they state that there is "*a clear need for 'facilitation' to focus on changing the circumstances or situation in which people live, rather than on concentrating solely on individual behaviour and knowledge*" (Twinn and Cowley, 1992:28). An assumption has been that adequate resources will be available for health visitors to refer clients onto. However a key feature of this research is that resources for families in need are often fairly limited. Health visitors particularly those in Sites A and C continually described situations of unmet needs. Indeed some health visitors demonstrated considerable persistence and creativity in finding resources for their clients.

11.11 Critique of Research Methods

While it is believed that the study findings do contribute to the health visiting theoretical knowledge base on professional judgement, it is important to acknowledge the limitations of this research study. An obvious limitation of the preliminary work was the fact that documentary analysis can only focus on the existence and nature of guidelines as reported by Senior Nurses and cannot comment on health visitors' adherence to these guidelines in practice. One advantage of the emergent study design was that this potential weakness was able to be addressed in the main study, by examining health visitors' use of practice guidelines in the context of the three case sites selected. Furthermore 'selective survival' (Webb et al, 1984) is always a potential problem when analysing documentary evidence and refers to the problem of incomplete, missing or censored data. When analysing documents out of context, information contained within documents may also lack clarification from associated training sessions.

In the main study the researcher has followed the conventions of a constructivist inquiry to explore the concept of health visitor professional judgement, hence the study findings represent one interpretation of the health visitors' constructions and experiences of professional judgement. The study findings are exclusive to the particular contexts under study and as such there was no intention to seek statistical generalisation which would be inappropriate in case study research. However, the researcher hopes that the descriptive interpretation resulting from the study, through

vicarious experience, will be meaningful to health visitors working in other similar contexts. The trustworthiness of the study is displayed through the rigorous and systematic approaches adopted during data collection and analysis and their critique and transparency throughout the thesis. Having the opportunity to present papers at national conferences further clarified the researcher's thinking as data analysis and writing up progressed.

An interesting feature of this case study was that as the study progressed the case variation, in terms of the impact of the contrasting guidelines on health visiting practice became less obvious, thus reducing the opportunity for formal cross case analysis. Yet as Vaughan (1992:176) has described, it is sometimes only through the processes of data collection and analysis that anticipated case "typological distinctions" may be found not to exist. In this collective case study, despite the case variation becoming less apparent, the cases still provided a very useful "opportunity to learn" about the issue of professional judgement (Stake, 2000:437). Data analysis centred on advancing understanding through a search for patterns across the three cases (Lincoln and Guba, 1995), in a process described by Stake (1995:74) as "categorical aggregation". This supports Bergen and While's (2000:931) view that case studies are appealing not only for "their uniqueness" but also "their commonality."

One of the key difficulties faced in gaining permission to undertake the study was negotiating access through various gatekeepers, the most problematic being Local Research Ethics Committees. Ethics committees varied in their requirements for written proposals and documentation. Lack of understanding by one committee about the purpose and nature of qualitative research proved to be a major obstacle in gaining approval for the study. In one site gaining ethics approval took over four months. In hindsight the process of gaining ethical permission for the study could have been eased somewhat by seeking access from a multi-centre ethics review panel.

One strength of the study's design was the opportunity it afforded to observe health visitors in their real life working contexts. An apparent advantage of accompanying the same health visitor on a number of home visits was to reduce the impact of observer

effect on health visitor practice. By accompanying practitioners on several visits it appeared that practitioners soon became accustomed to the researcher's presence. It also presented an opportunity to discover that some health visitors adopted different approaches with different clients, as Cowley (1991) and Bryans (1998) have previously indicated. However, a limitation of the design which resulted from observing only one health visitor interaction contact with each client, meant that it was not possible to consider how a health visitor's assessment practice and interventions might alter over a period of time with the same client. Neither was it possible to determine whether or not the client perspective would change as Pearson (1991) has previously identified and some clients alluded to in their experiences of different health visitors. This would be an extremely interesting area to explore further to examine the long term impact of health visitor assessment practices and interventions.

Furthermore it is also acknowledged that there are possible limitations incurred in not making full use of the audio-recordings. The audio-recording did provide a more complete record of the visit, providing a level of detail that would have been impossible to capture using field notes alone, and offering a valuable check for example, when recording changes to the health visitors' visit agendas (Table 9.2). It is recognised though that a systematic approach to conversation analysis could have been adopted, perhaps leading to a detailed understanding of "the sequential organisation of talk" (Heritage, 1984; Silverman, 1993:125). Conversation analysis, is primarily concerned with communication processes and "talk-in-interaction" (Silverman, 2000:97) and could have facilitated an understanding of the way in which health visitors' conversations with their clients are organised. However, this would have been largely outwith the main study objectives and given the detail of the study, a major challenge that the researcher faced was to limit and not to expand the study further. Pragmatically the amount of time that would have been needed to conduct conversation analysis on all of the tapes did not seem justifiable; it is recognised that all studies have to be limited in some ways.

Conversation analysis was deemed inappropriate as a broader focus needed to be adopted to achieve this study's objectives, for example, the purpose of each home visit and the health visitor's professional judgement to offer a client/family extra health

visiting support could not be The results from conversation analysis would not have yielded any information about the cognitive thinking processes that constitute professional judgement. The key issue is that professional judgement is not a verbal activity, although some aspects of it may be represented verbally. A systematic analysis of the taped conversations was carried out to show whether or not the health visitor verbalised her judgements and whether or not the judgements were participative (See Appendix 7.1), but greater detail about these issues would have fallen outside the study objectives.

Secondly, individual interviews were conducted with clients to examine client perceptions about the effectiveness of health visitor interventions in identifying and addressing needs; the use of conversation analysis would not have revealed any information about such client constructions. Furthermore in order to consider how formal guidelines contribute to the process of targeting health needs the researcher needed to take into account the wider context and consider for example, the extent to which health visitors used guidelines during their assessment interactions with clients. It is unlikely that conversation analysis would have yielded the kind of useful information elicited by interviewing the health visitors, although, again, the taped conversations provided a check on whether, in fact, the health visitors acted in the way they claimed.

11.12 Recommendations for future research.

Although this research has addressed the initial objectives of the study and explored a number of issues raised in the literature, it has certainly raised many more questions. As such a number of future research recommendations are made.

Utilising a case study guided by a constructivist methodology has proved a valuable strategy for the study of health visitor professional judgement and would certainly be a useful approach to utilise in future health visiting research. By integrating several methods of data collection, including observation of health visitor/client interactions combined with interviews with health visitors and their clients has resulted in a rich and detailed data source. The strengths and limitations of the different methods are counterbalanced to add rigor, depth and breadth. An unusual strength of the research

was the addition of the client perspective, which provided an opportunity to gather material to compare professional versus client perspectives about extra health visiting.

The study suggests that health visitors have a central role to play in working with families with increased health needs. A longitudinal study to measure the effectiveness of health visiting assessment practices and interventions with families receiving extra health visiting appears highly appropriate and necessary. Having the opportunity to observe health visitor interactions with the same client over a period of time, could provide very useful insights into the long term nature of health visitors' assessment practices. This would also facilitate further analysis of how professional judgements are shared with clients and progressed over time. It could also provide further insights into how client views might change over time. A further area for future research which was indicated by the data analysis but precluded from more detailed study as it was not the central focus of the current investigation, was how health visitors approaches seem to alter with different clients.

A key finding of the analysis was the integration of some health visitor intervention activities with assessment processes. Thus the analysis indicates that assessment is significantly intertwined with many other factors which are integral to the assessment process. It would be interesting to discover how needs assessment and health visiting interventions are taught during specialist practice education, in both the academic context and in clinical practice. There is currently little empirical evidence to explain how these important processes are taught in health visitor education. Furthermore the information contained in Appendix 10.1, summarising the range of needs presented by clients/families in the study provides a valuable resource that could be used as teaching material, to illustrate the range and complexity of health needs encountered by health visitors on a daily basis.

In terms of guideline development, one way forward might be to consider the development of a protocol for professional judgement. Here the general purpose of the protocol would be advisory, informative and supportive; not set in tablets of stone, but possibly acting as a form of trigger list for the practitioner. An aide memoire could contain a number of sound and valid research based reasons for offering a family extra support, such as those identified in Figure 10.2 which broadly

encompass the three inter-related dimensions identified by the Dept. of Health (2000). It would also need to recognise the changing nature and complexity of vulnerability and the fact that several interacting factors may result in a family experiencing stress. This type of guideline could be influential in depicting the importance of professional judgement. Health visitors would be encouraged to use a process of reflective practice to articulate what is making them concerned about a family/situation in order to try and justify the professional judgement that she/he is making. This type of aide memoire comprised of sound research indices could be a way of enhancing health visitor professional judgement.

11.13 Conclusion

To conclude, this thesis has addressed the initial study objectives and offers the first explication of professional judgement in the health visiting literature. It has taken a step forward in clarifying health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support. Existing guidelines can be particularly criticised for their lack of validity and limited research basis. A critical finding of the research is that even when formal guidelines exist, most health visitors use their own professional judgement in making family assessments. This has tremendous implications for practice and raises serious questions about why managers persist in facilitating their development.

The detailed constructions resulting from the inquiry contribute to the theoretical knowledge base of health visiting by explicating professional judgement and its relationship to needs assessment. The analysis suggests that the health visiting assessment process is a complex, interactive and serial activity, with health visitors co-ordinating information from a variety of sources in order to assess health needs and formulate professional judgements. A key finding of the analysis was the integration of some health visitor intervention activities with assessment processes. Thus the analysis indicates that assessment is significantly intertwined with many other factors which are integral to the assessment process. This clearly has implications for health visitor education where the complexity of needs assessment must be recognised in training staff in professional judgement.

Appendices

Appendix 2.1 – **Searching the Literature**

In systematically searching the literature the researcher drew on her experiences of having undertaken the part-time Systematic Review Development Programme Training at the Centre for Statistics in Medicine, Institute of Health Sciences, Oxford.

A number of steps were adopted and initially involved revisiting the study aim.

Study Aim

The overall aim of the study is to examine health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support.

The aim was broken down into key sections. Initially a brainstorming exercise was undertaken to identify a range of potentially relevant and possible search terms. Discussions with other researchers also provided fruitful ideas about finding better search terms.

Key terms used in the search included:

Client / problem	Professional group	Professional intervention(s)	Outcome
Client(s) in need	Health visitor/s	Professional judgement	Extra health visiting
Child(ren) in need	Health visiting	Decision making	Increased support
Families in need	Community nurse/s	Clinical judgement	Extra support
Vulnerable client/s	Public health nurse/s	Clinical guidelines	Increased intervention/s
Vulnerability	District Nurse/s	Clinical inference	Family support
Vulnerable families	Nurse/s	Judgement	
Child protection		Needs assessment	
Child abuse		Assessment of need	
At risk		Intuition	
High Concern		Tacit knowledge	
		Nursing knowledge	
		Problem solving	
		Gut feeling	
		Personal knowledge	
		Critical thinking	
		Reasoning	
		Clinical Reasoning	

Databases utilised in the search included (initially CD-Rom versions and more recently Web accessed versions) CINAHL (From 1982), British Nursing Index, Medline, AMED and Cochrane for on-line computer searches. This exercise was also complemented by a number of other strategies including manual searching, tracing key references to theoretical or research work cited in other papers, examining library catalogues, and follow up of relevant papers following conference attendance. Keeping up to date with the literature through, manual browsing of current journals and on-line journal contents alerting systems was also important. Searching was not always productive and led to many dead ends, with several papers being discarded as their content was too general, for example, focussing on population – based approach to needs assessment as opposed to individual assessment of child/family health. Others centred on descriptive accounts that were largely anecdotal and subjective in nature, for example, personal opinion articles about the types of professional skills needing in health visiting.

Appendix 3.1 – **Letter of Introduction to Senior Nurses**

Senior Nurse,

Dear ..... ,

I am currently undertaking work on a research study for a Ph.D. at the Department of Nursing Studies, King's College, London University. Having previously worked as a health visitor with Harrow Community Health Services Trust and currently part-time as a bank health visitor in North West Hertfordshire, I am undertaking an exploratory study investigating health visitors professional judgements and use of formal guidelines for identifying families requiring extra health visiting support.

The first stage of the study will involve an examination of guidelines currently in use by Community Trusts/Directly Managed Units in the NHS Executive regions in England for identifying and prioritising families requiring extra health visiting support.

I would be extremely grateful if you would consider completing the attached brief questionnaire and if you feel able to send me a copy of the health visitor guidelines currently in use in your area this would be most helpful to me. Please return both in the SAE enclosed. All information received during the course of this study will be strictly confidential. Information received will not be used for commercial purposes, but solely for the intention of this study.

I understand your time constraints, but I am particularly interested in learning your views and would very much appreciate your willingness to participate in this project. Please feel free to contact me at the above address or by telephoning me on ..... if you would like any further information about the study.

Thank you very much for your time and attention.

Yours sincerely,

Jane Appleton.

Lecturer.

Appendix 3.2 – **Senior Nurse Questionnaire**

Office Code

Health Visitor Guidelines for Families Requiring Increased Health Visiting Support

1. Does your Community Trust/Unit have any official guidelines for health visitors to identify children in need of protection?

Please tick appropriate box:

Yes ❑

No ❑

Not sure ❑

2. Does your Community Trust/Unit currently have any official guidelines to assist health visitors in identifying and prioritising vulnerable families requiring extra health visiting support?

(This is apart from families where there are currently no children on the child protection register).

Please tick appropriate box:

Yes ❑

No ❑

Not sure ❑

I am enclosing a copy of the guidelines currently issued to health visitors:

Yes ❑

No ❑

3. How long have these guidelines been in use?

Please tick appropriate box:

Less than 1 year ❑

Between 12 and 23 months ❑

Between 2 and 5 years ❑

Over 5 yrs and less than 10 yrs ❑

10 years or more ❑

Not applicable, no guidelines ❑

Please continue.....

4. Do these guidelines come in to 'contracting' arrangements?

Please tick appropriate box:

Yes ❑

No ❑

Not sure ❑

Please comment on this if you wish.

5. Please tell me about any research underpinning the guidelines issued to health visitors to assist them in identifying families requiring extra health visiting support.

6. Would you be prepared to allow the health visitors working in your community Trust/Unit to participate further in this study?

Please tick appropriate box:

Yes ❑

No ❑

Not sure ❑

If 'Yes' please attach your name and contact telephone number.

Thank you very much for your time and help in completing these questions

Please return the questionnaire in the SAE enclosed.

Appendix 3.3 – **Critique and Analysis Tool for Documents**

Critique Questions :	Comments
Part A - Authorship and body	
1. Questionnaire and document number	Office code for document.
2. Authorship	
3. What is its origin ? Is there any evidence which indicates how the instrument was developed ?	
4. What guidelines have been sent to the researcher ?	
5. What focus do the vulnerability guidelines take ?	
6. How are the guidelines formulated ?	
7. Length of the document.	
8. Do any instructions accompany the guidelines / checklist / document ?	
9. Are the instructions clearly defined ?	
10. How is assessment data recorded by the health visitors ?	
Part B - Family vulnerability	
11. What is the stated function of the guidelines ?	
12. What underlying assumptions are made about 'vulnerability' and families seen to be requiring increased health visitor support ?	
13. Is family vulnerability linked with child protection ?	
14. Do the guidelines recognise that vulnerability is a complex, ambiguous and transient concept ?	
15. Do the assumptions upon which the guidelines are based serve to clarify and/or help to stabilise the nature of vulnerability, or negate by failing to recognise the embedded complexities ?	
Part C - Professional judgement	
16. Is professional judgement valued ?	
17. If it is valued , at what level is it valued ?	
18. Does professional judgement stand alone ?	
19. Do the guidelines aid professional judgement ?	
20. Is professional judgement tagged on as an after thought ? A sort of let out clause ?	
21. What appears to be the relative importance of 'professional judgements' to the guidelines ?	
Part D - Reliability and validity	
22. Do the documents/guidelines provide any evidence of reliability ?	
23. Are there any errors in the instruments ? If yes, what ?	
24. Internal consistency – How clearly detailed and defined are the indices ?	
25. Are all the indices on the instrument measuring the same thing ?	
26. How have they been sampled ?	
27. Equivalence - Have any of the following issues been considered ? – training for HV users of the instrument, inconsistencies between HVs using the instrument, HV bias, standardised measurement schedule etc.	
28. Do the documents/guidelines provide any evidence of validity ?	
29. Do all the indices deal with vulnerability ?	
30. Has the content of the instrument been judged to be appropriate ?	
31. Are the indices robust ? can they stand alone ? Are they independent ? Are they valid concepts ?	
32. What research evidence supports the validity of the indices ?	
33. How successfully have the concepts been operationalised? Are each of the indices/ concepts identified measuring the concept they were designed to measure ?	
34. Are the indices accepted measures, if so why ?	
35. How clearly detailed and defined are the indices ?	
36. Is the 'halo effect' in operation ?	
37. Is the HV required to make a forced choice ?	
Part E - Risk factors /risk indices	
38. List of risk factors / risk indices.	

Appendix 3.4 – **Follow-up Letters to Senior Nurses**

Senior Nurse,

Dear ..... ,

You may remember in November 1994 I wrote inviting you to participate in a research study which I am currently undertaking whilst studying for a PhD at the Department of Nursing Studies, Kings College, London University. As I have not received a response from you I am writing again to ask whether you would be willing to take part in this study. I understand your time constraints, but I am particularly interested in learning your views and would very much appreciate your willingness to participate in this project. all information received during the course of this study will be strictly confidential. Information received will not be used for commercial purposes, but solely for the intention of this study.

I will just refresh your memory about the research study. it is an exploratory study investigating health visitors professional judgements and use of formal guidelines for identifying families requiring extra health visiting support. The first stage of the study will involve an examination of guidelines currently in use by Community Trusts/Directly Managed Units in the NHS Executive regions in England for identifying and prioritising families requiring extra health visiting support.

As I am undertaking a national study of 'health visitor guidelines' the more Senior Nurses I can encourage to be involved in the research, the more meaningful and valid will be the result. Thus any input you can offer me would be greatly appreciated. If you are able to participate in this stage of the study, I would be most grateful if you would complete the attached questionnaire and return it to me in the SAE provided. If you feel you able are unable to answer all the questions, please leave those ones blank. I would also like you to know that I am only asking you to complete the questionnaire and would not require further involvement from you in the study unless you expressed a specific interest.

Please feel free to contact me at the above address or by telephoning me on ..... if you would like any further information about the study.

Thank you very much for your time and attention.

Yours sincerely,

Jane Appleton.
Lecturer.

Appendix 5.1 – **Letter of Feedback to all Senior Nurses**

Senior Nurse Responding to Preliminary Questionnaire,

Dear .....

You may remember in November 1994 I wrote inviting you to participate in a research study which I was undertaking whilst studying for a Ph.D. at the Department of Nursing Studies, King's College, London University. This research was an exploratory study investigating health visitors' professional judgements and use of formal guidelines for identifying families requiring extra health visiting support.

I am writing to let you know that the first stage of the study which involved an examination of guidelines currently in existence in Community Trusts in England for identifying families requiring extra support is now complete. As promised I will give you a brief resume of the key study findings and details about how to obtain further information about the research:-

- A postal questionnaire was distributed to all Community Trust Chief Nurses in England (179) employing health visiting staff.
- The aim of the questionnaire was to establish the extent to which guidelines are in existence throughout the country and to examine their validity and reliability.
- Response rate – 156 (87%)
- Ninety-eight (63.2%) Trusts issue guidelines to assist health visitors in identifying vulnerable families needing extra support.
- Clinical guidelines were analysed using a documentary critique and analysis instrument.
- Guidelines varied markedly.
- Thirty-five (45.45%) were classified as checklists, scoring systems and screening tools.
- Many guidelines contain subjective criteria and give equal weighting to risk indices.
- Only nineteen (19.39%) respondents stated that the guidelines were based on published research.
- Questions are raised about the relationship between clinical guidelines and professional judgements.

The references for this study are :

Appleton J.V. and Cowley S. (1997) Analysing clinical practice guidelines. A method of documentary analysis. *Journal of Advanced Nursing* 25. 1008-1017.

Appleton J.V. (1997) Establishing the validity and reliability of clinical practice guidelines used to identify families requiring increased health visitor support. *Public Health* 111. 107-113.

I would like to take this opportunity to thank you for all your assistance in participating in this stage of the research. Please contact me on the number below if you would like to discuss any aspects further.

Thank you once again for your interest in this research.

Yours sincerely,

Jane Appleton. (Mrs.)
Senior Lecturer.

Appendix 5.2 – **An Initial Letter of Introduction**

Letter to Senior Nurse

14.12.95

Dear .....,

I am writing to thank you for participating in the first stage of my research study, you may remember I am undertaking a study exploring health visitors' use of professional judgements and formal guidelines for identifying families requiring extra health visiting support. I am currently working on this research for a Ph.D. at the Department of Nursing Studies, King's College, London University, being supervised by Dr. Sarah Cowley.

I am now in a position to approach Community Trusts to be involved in the second stage of this study and am therefore contacting you for this reason. To give you a brief summary of the proposed second stage of the project, pilot work will be completed in one area, with three Community Trusts being selected for the main study. Following ethics committee approval, the following parts of the study will run concurrently:-

Part One — Part One will involve 4/5 health visitors willing to participate in the study from each Trust being accompanied by myself on approximately five home visits each. The aim is to observe/record the interaction between health visitor and clients to examine the assessment processes taking place. Sally Kendall (1991) utilised a similar approach when investigating health visiting interaction and client participation in care.

Part Two. — Following each client/health visitor interaction, health visitors will be interviewed to examine assessment processes.

Part Three. Following the observed client/health visitor interaction, clients willing to participate further in the study will be interviewed to explore how client's perceive their own health needs and how they perceive the health visitors' role in relation to this.

I anticipate data collection to commence mid 1996.

Three Community Trusts have already agreed to participate in the research. I am particularly seeking an area to also take part where health visitors are not using any guidelines in their identification of families requiring increased health visitor support. I know in the letter which you kindly sent me you discussed some of the work that NHS Trust was currently undertaking with health visitors and at that time you were not issuing health visitors with any particular guidelines.

If you agree to participate in the study I would obviously be very willing to meet with your health visitors and discuss my proposed research project with them. I would also be very willing to share the research findings with you and your colleagues on completion of the study. For your interest I have enclosed a paper recently published in the Health Visitor journal detailing an earlier related study. This provided the preliminary focus for the current research.

If you would be willing for your health visiting staff to participate further in this study and/or if you would like any further details, it would be most helpful if you could contact me by telephone as soon as possible. I could then send you a detailed proposal and seek formal approval from your Ethics Committee

Thank you for your interest in this research so far and I look forward to hearing from shortly.

Yours sincerely,

Jane Appleton. (Mrs.)
Senior Lecturer.

Appendix 5.3 – **Study Site Access Approval Letters**

Mrs Jane Appleton,
Senior Lecturer
University of Hertfordshire
Hatfield Campus
College Lane
Hatfield, Herts
AL 10 9AB

7 December 1995

Dear Jane,

It was a pleasure to meet with you last week and discuss your intended research project.

I am writing to confirm that I have arranged the venue for you to come and present your work to us on Friday 2nd February, 12.15 - 1.45pm A sandwich lunch will be provided and I have booked an OHP and screen.

I have circulated details of your presentation to all health visitors, so we should get a good turn-out.

If I can be of any further help, please let me know. For your information I will be taking up the post of shortly, and will be moving bases though not sure where yet but you should be able to track me down. Also from 1.1.96 - 26.1.96 I shall be on annual leave If you have any problems and I'm not contactable, please refer to Clinical Development Advisor on

With best wishes,

Clinical Manager.

AP/DD
23rd July 1996

Mrs Jane Appleton
Senior Lecturer
University of Hertfordshire
Hatfield Campus
College Lane
Hatfield
Herts
AL10 9AB

Dear Mrs Appleton

Research into health visiting and professional judgement.

I am writing to give my permission for this research to be undertaken within the health visiting service of NHS Trust and for the Trust's health visitors to assist in the work subject at all times to client consent.

As I stated in our 'phone conversation, this research has my full support. It comes at a highly relevant time when we are looking at our visiting practice in detail and will asisst in presenting cases to our main purchasers. As we discussed, I hope that it will be possible for me to be involved in any interim reporting stage and I look forward to the results of this work as they become available.

Please do not hesitate to contact me on should you have have any other requirements.

Yours sincerely

Director of Community & Primary Services

TRUST

☎:

Ref:

Mrs. J. Appleton,
Senior Lecturer,
University of Hertfordshire,
Hatfield Campus,
College Lane,
Hatfield,
Herts.,
AL10 9AB.

16th November, 1995.

Dear Mrs. Appleton,

Further to your letter of 13th October, 1995, regarding your Ph.D. and health visiting assessment process. We would be delighted to participate in this scheme but would have to recommend that you would need to send your proposals to our Ethics Committee and have enclosed an application form for you to complete. The person to contact if you have any queries about that is , who is secretariat to the Ethics Committee and is based at , tel. no. within the Human Resource Department.

When you are ready to come and commence the study with us then I will request that or myself will set up a meeting to communicate this to the health visiting staff.

Yours sincerely,

Director of Nursing, Primary
and Child Health Services.

Enc:

1411ja

Tel Fax

M/s Jane Appleton
University of Hertfordshire
Hillside House
Hatfield Campus
College Lane
Hatfield
Herfordshire
AL10 9AB

Enquiries to: *Ext:*
Our Ref:
Your Ref:
Date: 19 February 1996

Dear M/s Appleton

RE RESEARCH PROPOSAL - AN EXAMINATION OF HEALTH VISITING PROFESSIONAL JUDGEMENT AND THEIR USE OF FORMAL GUIDELINES FOR IDENTIFYING FAMILIES REQUIRING EXTRA HEALTH VISITING SUPPORT.

Can I confirm that the Trust supports your research proposal and is able to offer the Health Visitors who are employed by the Trust to become part of your sample.

Following ethics submission and approval please contact me and we will discuss the details of getting your research started.

Yours sincerely

DIRECTOR OF NURSING AND QUALITY

Appendix 5.4 – **Correspondence with Ethics Committees**

Telephone enquiries, please contact

____ *Ext.* _____

Our Ref: _____ *Your Ref:* _____

Date: 20 March 1996

MS J V APPLETON
HILLSIDE HOUSE
UNIVERSITY OF HERTS.
HATFIELD CAMPUS
COLLEGE LANE
HATFIELD
AL10 9AB

Dear Ms Appleton,

Project Number 96/049 : An examination of Health Visitors' professional judgements and use of formal guidelines for identifying families requiring extra health visiting support

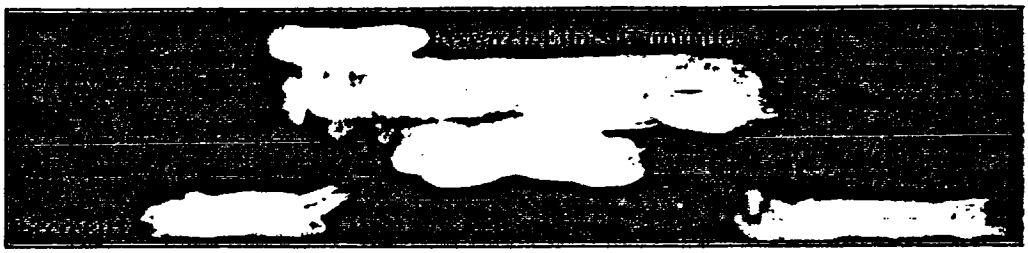
I am pleased to confirm that the above named protocol has been approved by the members of the Clinical Research (Ethics) Committee.

The Committee would be very interested to receive a copy of your findings at some future date.

Yours sincerely,

Chairman

(Ethics) Committee



25 April 1996

LREC/appleton

Mrs. J. Appleton
Senior Lecturer
University of Hertfordshire
Hatfield Campus
College Lane
Hatfield
Herts. AL10 9AB

Dear Mrs. Appleton

RE: AN EXAMINATION OF HEALTH VISITORS' PROFESSIONAL JUDGEMENTS AND USE OF FORMAL GUIDELINES OF IDENTIFYING FAMILIES REQUIRING EXTRA HEALTH VISITING SUPPORT

I acknowledge receipt of your letter and amended consent forms dated 19.4.96. I confirm that the amended consent form Appendix 1 (Form A) is acceptable and agree to it being used alone (as opposed to Appendix 2 Form B).

This study is now **approved.**

Yours sincerely

L.R.E.C. Chairman

Chairman:
Chief Executive:

6 September, 1996
Ref:

Jane Appleton
Senior Lecturer
University of Herts
Meridian House
32-36 The Common
Hatfield, Herts, AL10 0N2

Dear Ms Appleton

332 - An examination of health visitors professional judgements and use of formal guidelines for identifying families requiring extra health visiting support

I write to inform you that the amendments to the above study contained in your letter received 3rd September 1996, have been approved.

The Committee look forward to receiving a copy of your interim report in six months time or at the end of your project if this is sooner.

Yours sincerely

Chair

Please reply to:

RESEARCH ETHICS COMMITTEE

CHAIRMAN: SECRETARY

Our ref:
24 May, 1996

Tel: (Direct Line)
Fax:

Mrs Jane Appleton,
Senior Lecturer,
University of Hertfordshire,
Hatfield Campus,
College Lane,
Hatfield,
HERTS. AL10 9AB.

Dear Mrs Appleton,

AN EXAMINATION OF HEALTH VISITORS' PROFESSIONAL JUDGEMENTS AND USE OF FORMAL GUIDELINES FOR IDENTIFYING FAMILIES REQUIRING EXTRA HEALTH VISITING SUPPORT

Thank you for your letter of 3rd May.

As you know, your response to the Committee which was kindly enclosed with that letter was considered by the Committee at their meeting on Wednesday 22nd May 1996.

At that meeting it was agreed that your study be approved, without further proviso.

The Committee would be grateful to have a synopsis/summary of your findings in due course.

With best wishes,

Yours sincerely,

Secretary

All correspondence and enquiries should be addressed to the Secretary

Appendix 5.5 – **Pilot Study – Letter sent to health visitors**

Health Visitor,

..... Community Healthcare NHS Trust.

9.5.96

Dear .....,

Thank you for your interest in my study which was presented at ... Health Centre in February. I am currently working on a research study for a Ph.D. at the Department of Nursing Studies, King's College, London University, being supervised by Dr. Sarah Cowley. I am undertaking a study to examine the importance of professional judgements and the 'health visiting assessment process' in identifying health needs and prioritising families requiring extra health visiting support.

As you may know I am trying to elicit support from health visitors who would like to take part in the study. The research study has been fully discussed with management and they have agreed that I may approach you. Ethics committee approval for the research to be undertaken in ... Community NHS Trust has now been obtained and I am currently seeking three/four health visitors to participate in the pilot work. The focus of interest in this study is how health visitors make assessments in their day to day professional practice and the study is very much about valuing skilled health visiting. Pilot work is being undertaken in ... Healthcare NHS Trust to develop the research instruments and main study data collection will take place in three other Community Trusts in England.

The study involves three concurrent stages :

Part One — Will involve 3/4 health visitors willing to participate in the study being accompanied on up to 5 home visits each by the researcher to observe, record and tape-record the interaction between health visitor and clients to examine the assessment process taking place.

Part Two — Following each observed home visit health visitors will be interviewed. The focus of this interview will be the accompanied home visit and the aim of the interview will be to explore health visitors' professional judgements in identifying health needs and offering families extra health visiting support.

Part Three Following the client/health visitor interaction, clients willing to participate further in the study will be interviewed to explore how client's perceive their own health needs and how they perceive the health visitor's role in relation to this.

Informed consent will be obtained from all study participants. All information received during the course of the study will be strictly confidential and identities will not be revealed when the study findings are reported or published. On completion of the study I would be very happy to meet with you to discuss the research findings.

If you are interested in participating in the pilot work, I would be most grateful if you could return the cut off slip at the bottom of this letter in the SAE provided. Once health visitors have been identified, I intend to arrange a short group meeting with those health visitors to discuss methodological issues and talk about any further concerns/queries before undertaking pilot work June - August 1996.

Please feel free to contact me if you would like any further information about the study and I do hope you will consider being involved.

Thank you very much for your time and attention.

Yours sincerely,

Jane Appleton.
Senior Lecturer.

----------✂----------

... Community NHS Trust.

Name : _____

Base : _____

_____

Contact phone number : _____

Please tick as appropriate :

I would be interested in participating ❑

I would not be interested in participating ❑

I am not sure ❑

Appendix 5.6 – **Letter sent to health visitors in main study**

Ms. ...,
Health Visitor,
Community NHS Trust,

21.11.96

Dear Ms. ... ,

I am currently working on a research study for a Ph.D. at the Department of Nursing Studies, King's College, London University, being supervised by Dr. Sarah Cowley. Your name has been given to me by ... Locality Nurse Manager, as possibly being interested in taking part in this study. The research I am undertaking is a study to examine the importance of professional judgements and the 'health visiting assessment process' in identifying health needs and prioritising families requiring extra health visiting support. You may remember that earlier in the year I presented my study at ... Clinic in ....

At the moment I am trying to elicit support from health visitors who would like to take part in the study. I am therefore writing to ask whether you would be willing to take part as I am keen to learn your views as a health visitor. The research study has been fully discussed with management and ethics committee approval for the research to be undertaken in ... Community Care NHS Trust was obtained in September. I am currently seeking five health visitors to participate in the research. The focus of interest in this study is how health visitors make assessments in their day to day professional practice and the study is very much about valuing skilled health visiting. Pilot work has been undertaken in another Community Healthcare NHS Trust and I anticipate that main study data collection will begin in the ... area after Christmas. Two other Community Trusts are also involved in the main study and data collection has already started in those areas.

The study involves three concurrent stages :

Part One — Will involve five health visitors willing to participate in the study being accompanied by myself on 4 home visits each to observe, record and tape-record the interaction between health visitor and clients to examine the assessment process taking place.

Part Two — Following each observed home visit health visitors will be interviewed. The focus of this interview will be the accompanied home visit and the aim of the interview will be to explore health visitors' professional judgements in identifying health needs and offering families extra health visiting support.

Part Three Following the client/health visitor interaction, clients willing to participate further in the study will be interviewed to explore how client's perceive their own health needs and how they perceive the health visitor's role in relation to this.

Informed consent will be obtained from all study participants. All information received during the course of the study will be strictly confidential and identities will not be revealed when the study findings are reported or published. On completion of the study I would be very happy to meet with you to discuss the research findings.

If you are interested in participating in the study, I would be most grateful if you could return the cut off slip at the bottom of this letter in the SAE provided. Once health visitors have been identified, I intend to arrange a short group meeting with those health visitors to discuss practical arrangements and talk about any further concerns/queries before undertaking data collection next year.

Please feel free to contact me if you would like any further information about the study and I do hope you will consider being involved.

Thank you very much for your time and attention.

Yours sincerely,

Jane Appleton.

Senior Lecturer.

... NHS Trust.

Name : _____ PT/FT (Please ring)

Base : _____

_____

Contact phone number : _____

Please tick as appropriate :

I would be interested in participating ❑

I would not be interested in participating ❑

I am not sure ❑

Appendix 5.7 – **Formal Invitation letter to health Visitors**

Ms. ...,
Health Visitor,
Trust.

4.7.96

Dear ...,

Thank you for your interest in my study which was presented at ... Health Centre last Monday and for expressing interest in participating in the research. As you know I am undertaking a study to examine the importance of professional judgements and the 'health visiting assessment process' in identifying health needs and prioritising families requiring extra health visiting support. The focus of interest in this study is how health visitors make assessments in their day to day professional practice and the study is very much about valuing skilled health visiting.

Pilot work is currently being undertaken in another Community Trust and I anticipate that main study data collection will begin in the ... area in September 1996. Two other Community Trusts are also involved in the main study and data will be collected in all three sites concurrently.

The research study has been fully discussed with ... (Director of Nursing and Quality) and ethics committee approval for the research to be undertaken in ... Healthcare NHS Trust was obtained in March 1996.

I will just refresh your memory about the three stages of the study :

Part One — Will involve 4/5 health visitors (in each Trust) willing to participate in the study being accompanied by myself on up to 5 home visits each to observe, record and tape-record the interaction between health visitor and clients to examine the assessment process taking place.

Part Two — Following each observed home visit health visitors will be interviewed. The focus of this interview will be the accompanied home visit and the aim of the interview will be to explore health visitors' professional judgements in identifying health needs and offering families extra health visiting support.

Part Three — Following the client/health visitor interaction, clients willing to participate further in the study will be interviewed to explore how client's perceive their own health needs and how they perceive the health visitor's role in relation to this.

Informed consent will be obtained from all study participants. All information received during the course of the study will be strictly confidential and identities will not be revealed when the study findings are reported or published. On completion of the study I would be very happy to meet with you to discuss the research findings.

I am now trying to arrange a date when I can come to ... to have a short group meeting with the health visitors who have kindly agreed to participate in the study. The purpose of this meeting will be to discuss methodological issues and talk about any concerns/queries before starting data collection in Sept. 1996. This meeting will take no longer than 1 hour and I will try and arrange it somewhere in ....

I hope to arrange a meeting on the 15th or 16th August and would be really grateful if you could return the cut off slip at the bottom of this letter in the SAE enclosed ticking the times when you will be available.

Please feel free to contact me if you would like any further information about the study and once again thank you for agreeing to participate.

Yours sincerely,

Jane Appleton.
Senior Lecturer.

Name of Health Visitor:.....

I would be available to attend the research meeting on :-

Thursday 15th August 1996 at :		or Friday 16th August 1996 at:	
9.00 - 10.00	❑	9.00 - 10.00	❑
10.00 - 11.00	❑	10.00 - 11.00	❑
11.00 - 12.00	❑	11.00 - 12.00	❑
12.00 - 13.00	❑	12.00 -13.00	❑
13.00 - 14.00	❑	13.00 - 14.00	❑
14.00 - 15.00	❑	14.00 - 15.00	❑
15.00 - 16.00	❑	15.00 - 16.00	❑
16.00 - 17.00	❑	16.00 - 17.00	❑

I am unavailable on these dates : ❑

Appendix 5.8 – **Health Visitor Consent Form**

Health Visitor Consent Form

University of Hertfordshire/Dept. of Nursing, King's College, London.

Study Title : An examination of Health Visitors' professional judgements and use of formal guidelines for identifying families requiring extra health visiting support.

Researcher: Jane V. Appleton.

Health Visitor :

Health Visitor Base:

The researcher is carrying out a study to help provide information that might enable health visitors to identify families' health needs and develop a better understanding of the experiences of parents and the services that can be most helpful to them and their children. The study has been approved by ... (Local) Research Ethics Committee. I understand that the researcher will observe me during a number of home visits to clients on my caseload. I will select the clients visited and I will give an information sheet about the study to the GP of any clients participating in the study. My manager will also be informed about my participation in this study. I understand that during selected home visits I will be accompanied by the researcher, who will be observing the visit and tape recording my conversation with the client. Following each visit I understand that I will be interviewed at a time convenient to me. This interview will also be tape recorded. I will be asked some questions about the observed home visit and about my professional health visiting practice.

I understand that participation in the study is entirely voluntary, and that I am not under any obligation to take part. I know that even after the interview and/or observed visit begins I can refuse to answer any specific questions or decide to terminate the interview and/or visit at any time. I understand that the study data will be coded and

will not be linked to my name. My identity will not be revealed when the study findings are reported or published.

I have read this consent form, understand what this study involves and voluntarily consent to participate in it.

Date : Health Visitor's Signature :

Researcher's Signature :

Appendix 5.9 – **Client Information Sheet**

Client Information Sheet

An examination of Health Visitors' professional judgements and use of formal guidelines for identifying families requiring extra health visiting support.

I am a nurse researcher from the University of Hertfordshire undertaking the above study as part of my work for a higher degree in collaboration with the Department of Nursing Studies at King's College in London.

I would like to know if you would be willing to allow me to observe your Health Visitor when he or she visits you at home today and to tape record the visit. Later the same day I would like to meet you again and talk through your thoughts about the visit, how you perceive your health needs and the health visitor's role in relation to this. I would also like to tape-record this discussion. If you agree to take part you will be free to ask me to turn off the tape-recorder and/or to ask me to leave at any point during the two visits.

Your privacy will be maintained during the visits, you will not be identified by name, and the information gained will be treated as strictly confidential. Any direct quotes used in a final report of the study will remain anonymous.

Please do not feel obliged to take part in the study. You do not have to give a reason if you do not wish to participate. Your decision to participate or not participate will not influence the care you receive in any way.

Thank you for your interest and support with this study.

Jane Appleton.

Appendix 5.10 – **Health Visitor Interview Guide – Parts A and B**

Health Visitor interview Schedule

Part A:

1. Health visitor background information.
   Can you tell me a little bit about your career in health visiting? How long have you worked in the Trust? How long have you worked with this particular caseload?
2. Professional judgement.
   Professional judgement is a large topic area. What does this term mean to you?
3. Assessment processes.
   Can you describe how you would make an assessment of a family needing increased support? What factors do you draw on in determining that a family needs extra health visiting support?
4. Skills and knowledge.
   What skills and knowledge are needed to undertake such an assessment? What particular skills of assessment do you have? / Do you use
   Can you tell me what you believe are the most important skills/features when assessing family vulnerability and the need for increased support?
   Check out :- If you had to prioritise them, what are the most important factors in determining that a family needs increased support? What do you think are the key factors which influence your professional judgement to offer a family increased support?
5. Context data.
   Does your Trust have a service philosophy which influences your practice?
   Do you use any guidelines/ documentation in helping you to assess clients?
   Check out:- What do you think about this? Do you feel it is appropriate / useful? Overt/covert. Local protocol or not?
   Your Trust has an official guideline to assist health visitors in identifying families needing increased support, what do you think about this ?
6. Record of assessment data.
   Where do you record this professional assessment ?
7. Professional education.
   Did you have any input on needs assessment during your health visitor training?
   Anything since?

8. Increased family support
   Explore meaning. What is the nature of increased support that you can offer families? How many families on your caseload need increased support? Would you describe them all as vulnerable?
   Have you ever felt personally unable to give a family extra support ? Why was this? What happened? What did you do ?

Part B: **Picking up cues / significant events from the accompanied visit.**

9. Exploring assessment processes.
   Thinking back to the client we met visited this morning/afternoon :-
   Can you take me through your process of assessment in determining that this client/family initially needed increased support? How? Did you encounter any difficulties during your assessment of this family? Any prioritisation in assessment? When did you first identify that this family needed more support? How many times have you dealt with this type of situation ?
10. Perception of increased family support/ intervention.
    What preventive work undertaken? Nature of increased support. What do you think the family feels about this extra support you are offering them? Do you as a health visitor feel able to offer this family the increased level of support they need?
11. Additional support networks / services.
    Any additional agencies/support networks involved with this family? What support can you offer/arrange for this family outside the health visiting service? Do you have enough information about the services which might help meet the client's needs?
12. Exploring professional judgement
    Thinking back to this morning's visit, can you describe which incidents/episodes illustrated your use of assessment processes? Can you take me through your process of assessment of this client/family during the visit? Did you make any particular judgements? What was your rationale behind this? What factors influenced this? What factors generally influence your judgements? What skills and knowledge are needed to undertake this type of assessment? Any use of formal guidelines?
13. Relationships
    What type/sort of relationship do you have with this client? Could this (your) relationship influence your assessment to increase support to this family?
14. Reflection on visit
    What factors influenced you to ..... this morning/afternoon? What are most common? and most influential ? How many times have you dealt with this type of situation? Is there anything you would have done differently this morning?/ Like to add ?

Appendix 5.11 – Letter of Health Visitors Confirming Accompanied Visit Dates

Ms. ...

11.9.96

Dear ...,

It was a pleasure meeting you last Friday, thank you for your sparing your time to attend our discussion meeting.

I am just writing to confirm the dates when I will be visiting with you :-

- Wednesday 9th October, 1996
- Tuesday 12th November, 1996
- Thursday 12th December, 1996
- Friday 13th December, 1996

I will look forward to joining you in October and will ring you nearer the time to confirm our arrangements. Please contact me if you have any further queries about the study.

Thank you very much for agreeing to participate in the research.

With best wishes,

Yours sincerely,

Jane Appleton.
Senior Lecturer.

Appendix 5.12 – **Facesheet and Observation Record**

Home Visit Observation Record

Date of home visit :____ Reference number :____ NHS Trust: ____

HV Code number : _____

Client Code number : _____

Previous contact :

Length of time HV involved with family :

Family members :

No. of children :

Purpose of this contact visit :

Reason for family receiving increased health visitor support :

The setting - Description - who present ? Physical facilitators and constraints.

Interpersonal - Interpersonal facilitators and constraints. Interpersonal communication. Gaining knowledge, past history / present. Use of guidelines. Drawing on previous experience.

Issues/significant events to be raised in the interviews - Apparent judgements. Sudden changes in the course of the conversation.

Appendix 5.13 – **Client Consent Form**

Client Consent Form

University of Hertfordshire/Dept. of Nursing, King's College, London.

Study Title : An examination of Health Visitors' professional judgements and use of formal guidelines for identifying families requiring extra health visiting support.

Researcher: Jane V. Appleton.

Client :

Identification No.:

I have read the client information sheet and have had the opportunity to ask questions and discuss the study. I have received enough information about the study. I understand that taking part in the study is entirely voluntary, and that I do not have to take part. I am free to withdraw from the study at any time and know that all tape recordings would be erased immediately if I wished to do so. I know that my taking part or not taking part in the study, or my refusal to answer questions will not influence the care I or any member of my family receive in any way. I understand that if I decide to take part my GP will be notified that I am taking part in the study. My identity will not be revealed when the study findings are reported or published. On completion of the study all tape recordings will be erased.

I have read this consent form and agree to take part in this study.

Date : Clients Signature :

NAME IN BLOCK CAPITALS :

Researcher's Signature :

Appendix 5.14 – **GP Information Sheet**

General Practitioner Information Sheet

University of Hertfordshire/Dept. of Nursing, King's College, London.

An examination of Health Visitors' professional judgements and use of formal guidelines for identifying families requiring extra health visiting support.

I am a nurse researcher from the University of Hertfordshire undertaking the above study in collaboration with the Department of Nursing Studies at King's College in London.

... (Local) Research Ethics Committee has requested that I inform you that, as part of the above study, I will be observing and tape-recording a home visit between a health visitor and the client named below. Following this visit the client will be interviewed by the researcher and the client has consented to this.

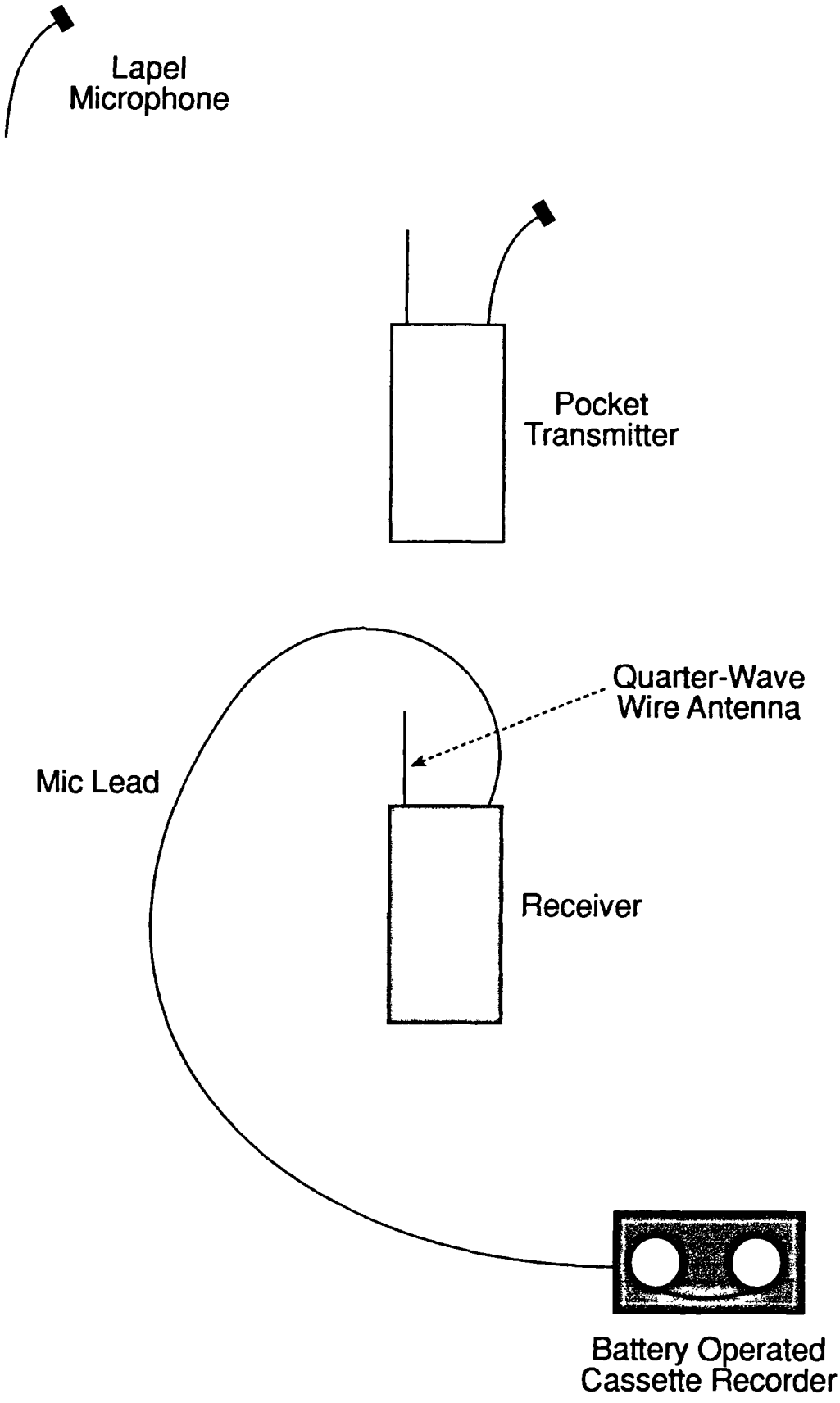
Client's name :

Client's address :

Researcher's name : Jane Appleton

Researcher's address :University of Hertfordshire,
Hillside House,
College Lane,
Hatfield,
Herts. AL10 9AB.

Appendix 5.15 – **Diagram of Wireless Transmission**



Appendix 5.16 – **Client Interview Guide**

Client Interview Schedule

1. Participant background information.
   Please tell me a little bit about yourself, your family and your children. How long have you lived in this area etc.
2. Thoughts/knowledge/attitudes towards Health Visitor role and function.
   What can you tell me about health visitors' and their role ?
3. Relationship with own Health Visitor.
   What is your relationship like with your health visitor? Length of time. Frequency of contact. Who decides?
4. Perceptions of health need.
   What would you say are your most important (health) needs? Do you regard these needs as health needs? Important to your health? Why have you decided this? Would your health visitor agree with you?
5. Thoughts about earlier visit.
   Thinking back to this morning's visit, what are your thoughts about it ?
   In terms of :-
   - The health visitors assessment.
   - Health visitor support given /offered
   - Other support offered /referral
   - Health visitor's apparent knowledge levels
   - Your expectations of the health visiting service
   - Your own needs
   - Your own involvement
   - Were there any difficulties encountered by you during the visit ?
   - Did you have the opportunity to discuss everything you wanted to?
6. Increased support/level of service.
   First, check family knows they are receiving extra support. I understand that you are getting some extra support from your health visitor, can you tell me a little bit about this please? What sort of support are you receiving? Does it help? What are your thoughts about this support? Is it acceptable? Would you like any other help? Have you discussed this with your health visitor?
7. Service provided by Health Visitor.
   Is the service which your health visitor provides acceptable to you / appropriate for your needs? What incidents / episodes illustrate this best How could it be improved? What alternatives are there?
8. Help received from other agency / person.
   Are you getting any help/support from any other person or agency apart from your health visitor ?

Appendix 5.17 – **Excerpt from Research Diary**

26.9.96. 10.30 am "Visited house as we had arranged last week. No reply. Key not in door but looked like key in the top lock - yale. Small windows at the top of lounge and bedroom open. Feeling a bit frustrated as I had made a long journey of 1 1/4 hours to visit client this morning. Could see the dog sitting in the hallway through the glass of the door. I pushed a note through the door to say that I had visited as we'd arranged and would try and contact [client] later today. (I had left a telephone message for HV yesterday asking if she would contact [client] yesterday, reminding her of my visit today - this message was left with the clerks - ? did it get through). I had the vague impression that somebody was at home. After this I went to the local clinic to meet HV, she wasn't there so after about 25 minutes I went back to see if [client] was in. This time [client] answered the door in her nightie. Said she had a cold, was sniffling and sneezing during the visit. Said she'd just got my note and apologised for not being up earlier. She had thought that I was possibly calling to see her yesterday, but when I didn't turn up she felt it was unlikely that I wouldn't have called. Quite happy to see me, was preparing baby's bottle, which she took upstairs for [partner] to give to the baby and then came into the long to talk to me. The atmosphere was very smoky and [client] continued to smoke throughout the interview."

Appendix 7.1 – Discovering Elements of Professional Judgement Elicited in the Data

Area A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
1.15.1	9	Yes	Process	1. To assess progress with 3½ year old's ENT problem, ear infections and treatment.
		Yes	Process	2. To discuss Consultant's planned management of ear infections with client.
		Yes	Process	3. To explore housing problems including harassment, police raid and housing needs.
		Yes	Process	4. To be realistic about family's chances of being rehoused.
		Yes	Process	5. To discuss client's bereavement and the funeral arrangements.
		Yes	Process	6. To explore how her grandmother is coping following her husband's death.
		Yes	Process	7. To assess and talk about child's development and speech therapy.
		Yes	Process	8. Decided with mum that she would contact SS to find out how long social worker away.
		Yes	Process	9. Will ring mum next week and see how she is.
1.15.2	6	Yes	Process	1. To talk about child's recent special needs assessment with paediatrician and parents views about this and how mum is coping with child's needs.
		Yes	Process	2. To reassure mother that the child's difficulties have not been caused be mum doing anything wrong.
		Yes	Process	3. To discuss with mum the problems the nursery are experiencing in managing child's behaviour.
		Yes	Process	4. Needs to establish child's behaviour in nursery.
		Yes	Process	5. HV will set up a meeting with the nursery school to raise their awareness of child's difficulties.
		Yes	Process	6. HV will also drop off a copy of the paediatrician's report to the nursery and speak with the special needs teacher.
1.15.3	15	No	Process	1. To make an assessment of mother's mental health.
		Yes	Process	2. To make an assessment of how mum is coping with the children and her levels of support.
		Yes	Process	3. To explore and ask about children's immunisations.
		No	Outcome	4. Mum unable to assess what's going on in her own life and whether she feels settled in house or not.
		Yes	Outcome	5. Client seems aware that she needs to find a GP, but no apparent level of urgency to this.

Area A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	6. HV doesn't feel she's making any headway with the family, only common agreement was on finding a GP.
		No	Outcome	7. Mum has very limited insight into children's needs particularly child's (2 yrs) emotional and safety needs and stimulation needs.
		No	Outcome	8. Client does not see a need for Family Centre support.
		No	Outcome	9. HV feels mum is not functioning at a normal rational level and could be depressed.
		No	Outcome	10. Concerned about the lack of interaction between mum and child.
		No	Outcome	11. Child (2 yrs) may need an assessment by Child Development Team because of developmental delay.
		No	Process	12. HV will phone Social Services in response to their call to her a couple of weeks ago regarding her concerns about the situation and to see if they will allocate a social worker.
		Yes	Process	13. Will see client in a month.
		No	Process	14. May "give her a knock" next week to see if she's been to see her GP.
		No	Outcome	15. HV doesn't feel she is making much progress with this family. Feels she's not achieving anything, there is a limit to how far she can push client feels she is monitoring situation, with mum digging her heels in and putting up the shutters.
1.15.4	7	Yes	Process	1. To assess how mum is getting on with structured sleep programme.
		No	Outcome	2. Mum more relaxed and confident.
		Yes	Outcome	3. Decided to leave the ball in mum's court, knows client will contact her if problems reemerge. Therefore didn't make another appointment. Encourages client to keep going and knows client will come back if she needs to.
		No	Outcome	4. End of an episode of increased support. Had thought there would be more problems and suprised mum progressed so well.
		Yes	Outcome	5. 10 mth baby's sleep problems have improved, mum has made a lot of progress.
		No	Outcome	6. Thinks things will deteriorate again but is "reserving judgement".
		No	Process	7. Will review case in clinic.
1.25.1	10	Yes	Process	1. To check with mother how things are with her husband and to find out when the court date is.
		Yes	Process	2. To assess how pregnancy is progressing and has she made any plans yet.
		No	Outcome	3. Mum's relationship with children is quite warm and HV has no child protection concerns.

Area A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		Yes	Process	4. To assess how mum is coping with the situation.
		Yes	Outcome	5. Mother admits being very low and depressed. Mother lower than HV had thought.
		Yes	Outcome	6. Mother recognises she is making no plans to deal with the new baby, but not wanting to address this.
		Yes	Process	7. Plans to do 2 year check later this week discussed and arranged with mother
		No	Outcome	8. Baby alive and growing and being monitored by midwives.
		Implied	Process	9. Continuing increased support, mother still needs a lot of continuous support, she remains high intervention.
		No	Outcome	10. HV not anxious about the situation.
1.25.2	10	Yes	Process	1. To find out how mum is getting on with weaning the baby and to discuss any anxieties surrounding this.
		Yes	Process	2. To assess both children's weight.
		No	Outcome	3. 3 year old developing fine.
		Yes	Process	4. To assess where mum is at with the dietician and speech therapist.
		Yes	Outcome	5. There is progress in how mother is managing 3 year old child's behaviour.
		Yes	Outcome	6. HV wanting client to recognise the progress mum has made in managing this behaviour.
		No	Outcome	7. Client requesting help completing DLA form, HV then judged this as a need.
		Yes	Outcome	8. Mum coping.
		Yes	Process	9. Visits will need to be less frequent (therefore decreasing level of extra support).
		Yes	Process	10. Will continue to weigh 3 year old monthly at home.
1.25.3	11	Yes	Process	1. To assess the situation now family are being subjected to extra stress at home.
		Yes	Process	2. To find out what's happening with 5 year old's school provision.
		No	Outcome	3. Assessed mother's emotional state and she's clearly not depressed.
		Yes	Outcome	4. [Named] local nursery is appropriate for child as deals specifically with children with speech and behavioural difficulties.
		Yes	Outcome	5. HV open with mum about the fact that special needs child (5 yrs 8 mths) needs continued educational support and speech therapy.
		No	Outcome	6. Father's diabetes not too bad - diet controlled, not on medication.

Area A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		Yes	Outcome	7. Mum coping with relationship with husband, it's difficult but she's coping with it.
		Yes	Process	8. HV will follow up on child's educational programme and speech therapy. Will liase with education officer and speech therapist. Will follow up on services for child.
		No	Process	9. Family still need extra support - situation not resolved, lots of anxieties within the home because school not in place yet. Feels situation is very stressful for mum, worrying about what is going to happen, plus has added stress of nephew living in the house.
		No	Outcome	10. Special needs daughter has regressed physically and developmentally. She needs a lot of support.
		Yes	Outcome	11. Mum coping with the whole situation.
1.25.4	6	Yes	Process	1. HV will use her own personal connections to find out about and try and obtain counselling services for client.
		Partly	Process	2. HV will go and see client at home, once she has found out about counselling services. She told mother she would phone her.
		Yes	Outcome	3. Client has not moved forward in terms of sorting out her work problems and child care arrangements.
		Yes	Outcome	4. Mum relating well to baby.
		Yes	Outcome	5. Mum working at home, coping, managing baby well and doing a good job with baby.
		Yes	Outcome	6. 5 mth baby's developmental progress within normal milestones.
1.39.1	8	Yes	Process	1. To weigh 4 week old baby.
		Yes	Process	2. To discuss baby's development, health and feeding.
		Yes	Process	3. To explore and assess how mum is coping with older child 16 months.
		Yes	Outcome	4. Mum's handling of the baby is very appropriate.
		No	Process	5. HV needs to concentrate on mum and her relationship with older sibling 16 months.
		No	Outcome	6. Mother's stress levels as great as before, but she is catching up on sleep.
		Partly	Process	7. Will visit again (this is shared with mother) to see if mum still on top of the situation when Dad not around. Also to reassure herself about mother's relationship with 16 month old (not shared).
		Yes	Outcome	8. Sibling rivalry and how mum managing this has improved since last visit - but could worsen - so continued need.
1.39.2	17	Yes	Process	1. To assess baby's feeding routine.
		Yes	Process	2. To undertake Health Profile.

Area A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		Yes	Process	3. To assess how mum is coping following caesarean section and new baby.
		Yes	Process	4. To assess mum's physical health.
		No	Outcome	5. Mum calmer.
		Partly	Outcome	6. Mum unable to recognise that her expectations of herself and the baby are too high. HV raises this in relation to baby but not mother. Does say to mum that she recognises it is stressful for her.
		No	Outcome	7. Client has feelings of inadequacy, which seem to be increasing. HV has concerns about a "combination of things mum said."
		Partly	Outcome	8. Mum worried about going back to work (she mentions this at every visit). HV explains to mum how she could take time off sick following period of maternity leave.
		No	Outcome	9. Fine line between telling client you're concerned about baby care and waiting to see what happens.
		No	Outcome	10. HV worried about this post-natal mum.
		No	Outcome	11. Client has symptoms of early PND so HV has alerted GP. Thinks client is depressed .
		No	Outcome	12. Seems unable to hold 3 week old baby - query separating herself from her.
		No	Outcome	13. Thinks client does not recognise the problem with not handling baby.
		Yes	Process	14. Will visit client in two weeks time.
		No	Outcome	15. On reflection wishes she had not asked mum if she'd been admitted to a psychiatric ward. (HV's assumption)
		No	Outcome	16. On reflection wished she'd asked client more about coping with baby alone and about leaving the baby anxious about the situation.
		No	Process	17. Client definitely needs extra support.
1.39.3	12	Yes	Outcome	1. Not appropriate to address sleep problem at this stage.
		No	Outcome	2. Mum very negative about the older children's behaviour.
		Yes	Outcome	3. Mum "below rock bottom."
		Partly	Outcome	4. HV concerned about mum's mental state and not her care of the children. Mum's mental state more of a concern to her than it has been before. She acknowledges to client that she recognises that she is extremely low at the moment and that she looks exhausted.
		Yes	Outcome	5. Mum needs a break - even "a week in hospital for a rest."
		No	Outcome	6. Mum and Dad don't communicate at all, it could be useful for both to have Relate counselling. Father has some awareness of mother's need for help but does not know how to give it. It's difficult for mum to say she's not coping/ has always run around after him and the kids.

Area A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	7. Needs are greater than HV originally thought - mum is very fragile.
		Yes	Process	8. Needs to get some help sorted out for mum from Social Services, will contact them. (Client recognises she needs support).
		No	Process	9. Increased support needed to get mum to feel better about herself. May need on-going support from HV and other agencies every week for some time. (Client recognises she needs support).
		No	Outcome	10. Mum had negative role models as a child herself, therefore unable to fulfil her own children's needs and be positive about her own parenting, usually negative towards children "It's just dawned on me today."
		Yes	Process	11. Will visit client at home next week.
		Yes	Outcome	12. To refer 5 year old to speech therapist as rolling tongue along the bottom of his mouth.
1.39.4	5	No	Outcome	1. Mum feeling low about the pigeon situation and the flat.
		No	Outcome	2. HV does make some value judgements about mum's intelligence levels and the type of client she is. HV is aware of doing this and making such judgements.
		No	Outcome	3. HV is unsure about the value of the visit for client - HV feels she's not achieved much, just gathering more information about the pigeon problem, about the "situation ... for future reference really." (HV certainly didn't appear to do much, but client very pleased with input).
		No	Outcome	4. 3 year old child progressing well developmentally - "able child".
		Yes	Outcome	5. Agrees to write letter to the housing department about the pigeon problem.
1.39.5	5	Yes	Process	1. To discuss child's eating and weigh him.
		No	Outcome	2. Mum coping and dealing with the current situation.
		Partly	Outcome	3. A lot going on but under control. HV acknowledges to client "...there's always something, isn't there?"
		No	Outcome	4. Mum fairly laid back and calm about surgery (minor operation) for special needs next week.
		Yes	Process	5. Will contact Mum next Friday "I'll pop in next Friday" - will phone beforehand, to see how surgery has gone.
1.70.1	7	No	Process	1. To observe children's bonding with mother.
		Yes	Process	2. To make an assessment of the children's weight, by weighing them.
		No	Outcome	3. At moment feels the triplets (5 months) "emotional environment is a bit bare."

Site A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	4. Mum unable to give much emotional input, HV feels she ought to address physical and emotional stimulation at some point. Feels father offering it. Justifies why it may not be appropriate to address this issue at point with mum.
		No	Outcome	5. HV feels mum is making emotional progress and responding in a more positive way towards children. Describes her assessment of mother's interaction with the children, as being more spontaneous. (HV making comparisons). Mother is generally coping a lot better.
		No	Process	6. HV will ask mum to bring triplets to clinic for weighing and will make a visit to focus on mum and see how she is.
		No	Outcome	7. Mum still unsure of herself.
1.70.2	8	Yes	Process	1. To make an assessment of how mum is coping.
		Yes	Process	2. To explore and find out if there is any pre-school input available for child.
		Yes	Outcome	3. Thinks mum still has a lot of anger - but coping mentally and emotionally with children.
		Yes	Outcome	4. Improvement in mum's management of children's behaviour and a general improvement in the children's behaviour.
		Yes	Outcome	5. Mum taking more interest in children's development now some of her own needs are being satisfied.
		Yes	Process	6. As mum coping better HV could reduce visits to monthly as getting help from family centre. Maturing process enabling mum to contact HV. HV comments "but the main decision anyway was to pull a bit further away from mum."
		Yes	Process	7. HV to follow up with housing department concerns about temporary accommodation.
		No	Outcome	8. Mum improving and coping much better, now making decisions herself i.e. to go to mother and toddler groups.
1.70.3	6	Yes	Process	1. To assess how mother is getting on.
		Yes	Process	2. To assess how child's (7 mths) development is progressing.
		No	Outcome	3. Relationship between mum and 7 month baby girl - [child 1] is developing well.
		Yes	Outcome	4. Mum seems more positive about accepting other twin's handicaps and dealing with [child1] more positively. HV displays acknowledgement that mother works hard with both children, that she is observant and picks up on their development.
		No	Outcome	5. Mum coping well with the children's needs but HV unsure how she is coping with her own needs.
		No	Process	6. Feels she needs to go back and see mum and check out whether she followed through her suggestion on getting help around the house. HV open with mum about client needing to get some help.

Site A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
1.70.4	7	Yes	Process	1. To assess where mum feels she's at in her relationship with 15 month old child.
		No	Process	2. To observe the interaction of mother and child.
		No	Outcome	3. Mum still vulnerable - limited emotional involvement with her child, HV thinks this is related to mum not resolving problems with her own mother. (Client says she thinks that HV does not believe that all is ok with her.)
		Yes	Outcome	4. Client has moved on - now able to make a reasonable assessment of her own situation and relationship with her 15 mth baby - child getting emotional support from her dad.
		Yes	Process	5. Will withdraw extra support - client to contact her with any needs.
		No	Process	6. If HV doesn't see client in 3-4 months she will phone her to satisfy herself as a professional that she made the right decision.
		No	Outcome	7. Risk of physical abuse to child is reduced.
1.82.1	14	Yes	Process	1. To talk about child (13 years) with mum.
		Yes	Process	2. To support mum.
		Yes	Outcome	3. Feels mother needs long term counselling and probably psychotherapy.
		No	Outcome	4. Client doesn't relate well to people who are from the same cultural background as herself.
		Yes	Outcome	5. Thinks client needs to take some action against the system which abused her to address her anger.
		No	Outcome	6. No concerns about the mother/baby relationship at the moment.
		Yes	Outcome	7. 3 month old baby unwell.
		No	Outcome	8. Has some concerns about hygiene in the kitchen and its possible relationship with baby's diarrhoea.
		No	Outcome	9. Mother has some underlying concerns about her 13 year old son. (HV attempted to address with client - but client changed conversation to another issue).
		No	Outcome	10. Mother does not have a lot of faith in her GP.
		Yes	Process	11. Offered to re-refer the family to child guidance
		Yes	Process	12. HV will contact client in 2-3 weeks on her return from holiday.
		No	Outcome	13. Mum concerned about baby's ill-health and appears to be doing the right things in response to this.
		No	Outcome	14. Mum able to express what she needs and gets quite a lot of help and support from her friends that are around.

Site A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
1.82.2	8	Yes	Process	1. To assess child's behaviour - how this is being managed at home and at school.
		Yes	Process	2. To make an assessment of child's (2 years) sleeping problem.
		No	Outcome	3. Family willing to take on board advice i.e. about child 6½ yrs.
		Yes	Outcome	4. 6½ years old's behaviour seems to have improved at home, however his behaviour at school is an unresolved problem.
		No	Process	5. Will continue to give family extra support because father may be more or less incapacitated by forthcoming investigations. (His support enables mum to cope).
		Yes	Process	6. Wants to monitor 11mth baby's development.
		No	Outcome	7. Has no concerns about child's (2 yr old's) development.
		Yes	Process	8. Will follow-up 2 year old's sleep problem in clinic next week and use this as an opportunity to also follow-up on child's (6½ yrs) behaviour.
1.82.3	11	Yes	Process	1. To assess how things are going.
		Yes	Process	2. To assess how mum is coping and managing with dressing child's finger or to find out if community paediatric nurse is doing it.
		No	Outcome	3. HV walking a fine line between being accepted and not being accepted, therefore prioritising what needs addressing.
		Yes	Outcome	4. Mum coping with child's (2½ years) potty training.
		No	Outcome	5. Concerned that mum is finding it increasingly difficult to deal with child's (5½ years) behaviour.
		No	Outcome	6. Feels there may be a degree of emotional deprivation or abuse with this child, because of mother and her partner's negative attitudes towards him.
		No	Process	7. Will ensure that child (5½ years) is assessed by the educational psychologist in school.
		Yes	Process	8. Needs to follow-up child's (5½ years) speech therapy appointment, he was assessed 7 months ago and has quite severe language delay and attention deficit.
		No	Outcome	9. Feels she is not making any progress with family. Monitoring and keeping an eye on them "on strictly health grounds". Looking for an excuse to visit to check children are alright.
		No	Outcome	10. Has concerns about children's emotional and physical well-being.
		No	Outcome	11. Reflecting on the visit would have liked to have asked about mum - particularly as there had been a health query at the last visit.

Site A Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
1.82.4	7	Yes	Process	1. To assess how mum is and how she is feeling.
		Yes	Outcome	2. Attending two parenting courses has enabled mum to cope with the children better.
		No	Outcome	3. Felt mum letting go - has made progress and no longer needing increased intervention. Mum more relaxed and calm.
		Yes	Process	4. HV to telephone mum in 2 months time in September.
		No	Outcome	5. Feels there has been an improvement in mother's situation, mum more positive about going to do things for herself, but not convinced it's the end of the story - continued improvement will depend on a lot. Mum still has to see the occupational health doctor. Leaving things open if mum needs to come back to her, she knows mum will contact her if necessary.
		No	Outcome	6. "My gut feeling is this isn't the end of it you see." Not the end of the road because still lots of unresolved issues. Mum is still feeling low and she is still not feeling the way she would like - continues on antidepressants and there is still pressure on her to return to work.
		No	Outcome	7. End of an episode of increased support.

Site B Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
2.06.1	6	Yes	Process	1. To give mum support and the chance to talk over some issues that are happening.
		Yes	Process	2. To clarify what the situation is with (ex-partner) and to look at the risks of the situation again.
		Yes - Partly	Outcome	3. At the moment the risks have subsided (and HV's anxiety is reduced about mum moving back to the flat).
		Yes	Outcome	4. HV thinks it's positive client has made another appointment for counselling Mum moving forward.
		Yes	Outcome	5. Feels client would contact the police if in danger.
		Yes	Process	6. Will meet with client next week, to see if counselling at the drug and alcohol centre is helping mum and if so, reduce her contact with client.
2.06.2	8	Yes	Process	1. To support Mum.
		Yes	Process	2. To assess if mum has done anything about contacting Social Services regarding her father and about moving to be nearer her sister.

Site B Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	3. Client has looked into the move a lot and has made considerable plans for herself and 18month child for the future.
		Yes	Outcome	4. Mum has got concerns about her younger sister who was sexually abused by her step-father, but feels that when he comes out of prison mum will take steps to protect her sister.
		Yes	Outcome	5. Client has moved on considerably. (Client also thinks this is the case).
		No	Outcome	6. Has got over her personal confusion.
		Partly	Outcome	7. Client is no longer coming across as vulnerable and insecure - HV made this judgement from observation of client's appearance, what she was saying, the way she said it. No longer questioning she's doing the right thing.
		Yes	Outcome	8. Wanted client to decide where they went with the visiting from here, but felt confident that client would still contact HV if she needed to.
2.06.3	6	Yes	Process	1. To offer general support to mum around her mental health needs.
		Partly	Outcome	2. 9 week old baby unwell. (Tries to get client to take responsibility and recognise baby's deviation from norm).
		No	Outcome	3. Mother's needs take priority over children leading to behavioural problems with 4 year old boy.
		Yes	Outcome	4. Will return to weigh 9 week old baby tomorrow.
		No	Outcome	5. Lots of contradictions in client's situation, mother's binge eating a cry for help, problems may stem back to her own childhood.
		Yes	Process	6. Arranged to see client in a fortnight to provide continuity of increased support to mother.
2.06.4	6	Yes	Process	1. To show letter to (Charitable Organisation) and discuss with mother.
		Yes	Process	2. To assess how mum is doing and assess her needs.
		Yes	Outcome	3. There's an improvement in mother's emotional well-being.
		No	Process	4. HV needs to monitor child (2 yrs 8 months) and her development.
		Yes	Process	5. Will send form to Consultant Paediatrician for medical report on child's history of special needs.
		Partly	Process	6. Feels there is a need to go back to offer support to mum. (Not shared - Feels problems may be ongoing and situation could deteriorate if mother's health deteriorates as a result of her reduced medication intake.)

Site B Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
2.20.1	5	Yes	Process	1. To offer mum support in developing her confidence in her parenting skills.
		Yes	Process	2. To offer help with 4 year old's behaviour and language difficulties.
		No	Outcome	3. Mum handled 4 year old's difficult behaviour well.
		No	Process	4. Needs to discuss feeding of 7month old baby with mum a bit more when he is a little bit older. Will probably do a home visit in January (2 months time).
		No	Process	5. Wanting to work with mum to wean baby off the bottle.
2.20.2	11	Yes	Process	1. To see how child is getting on at playgroup and how her general behaviour is.
		Yes	Process	2. To discuss ways of stimulating child and to find out what she has got in the house and whether she belongs to the library.
		Yes	Process	3. To weigh baby.
		Yes	Outcome	4. Both children (baby 6 months and 3 year old girl) have sleep problems.
		No	Outcome	5. Mum's interactions with the children are quite different. child (3 year old) is a problem to her and child (6 months) is not.
		Yes - Partly	Outcome	6. Parents expectations of child (3 years) are too high - unrealistic. HV attempts to address this mother.
		No	Outcome	7. Does not feel that mother realises the work involved in having a bright child (3 years). HV feels that raising client's awareness about child's need for stimulation and play is going to be a long term issue.
		Yes - Partly	Outcome	8. Child (3yrs) is still drinking from a bottle and has a dummy and should be weaned off them. (HV feels she's using them for security, but does not share this judgement with mother).
		Yes	Outcome	9. Child's (6 months) feeding pattern needs to be altered.
		No	Outcome	10. Will need to address home safety issues with mother when baby starts to crawl and move around.
		No	Outcome	11. Health visitor input with this family will continue over the long term - "a constant drip", if I mention it often enough, she might change.
2.20.3	5	Yes	Process	1. To undertake child's 18 month developmental check.
		No	Process	2. Family "needs an eye kept on them, here anything could flare up".
		Yes	Process	3. To find out why child has not had her school medical.
		Yes	Process	4. Needs to monitor 18 month old's speech and eye sight.
		Yes - Partly	Process	5. Intends to visit family in May and then every 6 months (to keep an eye on them - not shared).

Site B Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
2.20.4	8	Yes	Process	1. To undertake child's 18/12 assessment.
		No	Process	2. "To keep an eye on the family".
		No	Outcome	3. Didn't feel it was appropriate to address safety today, despite 3½ year old picking up an inhaler.
		Yes	Outcome	4. 14 month old's development progressing well.
		Yes	Outcome	5. 3½ year old's development progressing well.
		Yes	Outcome	6. Concerned re length of time taken for child's (3½ year old) statement (can take 2 years).
		Yes - Partly	Outcome	7. Concerned about mum and her need to see a doctor to sort out contraception (HV shares this judgement with parents) Mum drifts - she is unsure about getting a job, she is taking no firm action on loosing weight, she is very reliant on partner.
		No	Outcome	8. HV continues to be concerned about 7 year olds emotional and physical development.
2.38.1	8	Yes	Process	1. To assess how mum is feeling.
		Yes	Outcome	2. No need to rush back to see client - family as a whole making progress and particularly mother.
		No	Outcome	3. HV feels client will contact her if she needs to.
		Yes	Process	4. Decided to raise issue of youngest child's (23 months) dummy.
		No	Outcome	5. 6½ year old girl is fine.
		Yes	Process	6. Will need to continue to work with the family around 23 month old's bottles, teeth and diet.
		Yes	Outcome	7. Mother's tolerance of children has improved.
		Yes	Process	8. HV will phone mum after Christmas in 2-3 months time -to see if she needs to implement a behaviour modification programme for 23 month old's night time waking.
2.38.2	7	Yes	Process	1. To discuss resuscitation and lend 'Breath of Life' video.
		No	Process	2. HV feels she needs to give mum support.
		No	Outcome	3. Mum's anxieties still there but reducing. She is beginning to cope. OK emotionally.
		No	Process	4. To continue with visits but no more than once a week, therefore reducing increased support.
		No	Outcome	5. HV is confident mum will ask for help if and when she needs it.
		Yes	Outcome	6. 8 week premature baby's weight fine, HV happy with it.
		Yes	Process	7. HV arranges a visit for 6 days time, but client says this is HV's decision.

Site B Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
2.38.3	5	Yes	Process	1. To discuss weaning and the weaning process.
		Yes	Process	2. To discuss immunisations and check out if mum wants to attend baby clinic or GP surgery for baby's immunisations.
		Yes - Partly	Process	3. HV aims to maintain a monthly/6 weekly contact until baby's 8 month check. (Arranged a visit in 5 weeks therefore only partly shared as no rationale given to client).
		No	Outcome	4. HV aware of her own limitations with regard to her specialist knowledge re baby's diet and wanting to ensure dietician would be involved with client.
		No	Process	5. To follow up the outcome of the appointment with the dietician so that HV can reinforce information given to mother.
2.38.4	5	Yes	Process	1. To offer support and reassurance and to follow-up on breast feeding.
		Yes	Process	2. To weigh 5 week old baby.
		Yes	Process	3. To show mother baby's weight plotted on centile chart.
		Yes	Outcome	4. Would not have to visit again this week.
		No	Process	5. Reducing amount of increased support, for client's own development, self-sufficiency and confidence.
2.77.1	5	Yes	Process	1. To assess how child is developing.
		No	Process	2. To assess situation with boyfriend who is looking after new baby.
		No	Outcome	3. From her description HV appears to have made a judgement about mother's relationship with baby (11 months) and the fact that she will prop her in the chair, from the accumulation of information that has been presented to her over a period of time "that's exactly what she does."
		Yes	Outcome	4. Client and HV need to sort out hydrocephalic baby's nursery provision, HV will contact SCMO about this.
		No	Outcome	5. "Not the sort of woman, really, to be tied down with a mentally handicapped child."
2.77.2	8	Yes	Process	1. To undertake child's 18/12 assessment.
		No	Process	2. To assess how mum is coping.
		Yes	Outcome	3. 18/12 olds health now much improved - he's much better now.
		No	Outcome	4. Feels her intensive input with mother with her first child has paid off in helping her to manage her second baby. (This reflects intermittent nature of HV support). Mother now coping much better.

Site B Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	5. Will not visit again unless client requests a visit from HV. Mother is just tired, but she appears to be coping now. "I felt that my sort of four, five week, sort of high input has actually got her out of the worst of it." Client now ready to come up to health centre/clinic.
		No	Process	6. Needs to work with mum in taking a more relaxed approach if child has an accident.
		No	Outcome	7. Mum a lot calmer and in control. "I thought we'd turned the corner, which is a relief".
		Yes	Process	8. HV made a judgement to make the 18 month assessment visible to client - "into a ritual."
2.77.3	10	Yes	Process	1. To continue to listen to mother and offer support.
		Yes - Partly	Process	2. To give mother the confidence to sort things out for the future.
		Yes	Process	3. HV thought client needed to talk about the possibility of her child (2 years) dying during heart surgery. "it had to come sooner or later. I had to force the issue."
		Yes	Process	4. To give mum a hug.
		Yes	Outcome	5. 2 year old developing very well, much happier and contented child.
		Yes - Partly	Outcome	6. Parents have moved forward in recognising 5 year old's needs, instead of focussing all concerns on 2 year old with heart problem. HV positively reinforces mother's description of how they are dealing with the 5 year old's needs, when brother is admitted to hospital.
		No	Outcome	7. Gut feelings told me she's a lot better than she has been, but mum has gone down since last visit. Gut feelings stimulus for the visit.
		Yes	Outcome	8. HV thinks client has a lot to face and has done well.
		Yes	Process	9. HV to sort out problems with the level of payment under the Disability Living Allowance.
		Yes	Process	10. Will liaise with local charities and try and sort out some financial assistance for the family
2.91.1	7	Yes	Process	1. To follow-up and assess if mum has maintained progress.
		Yes	Process	2. To see if mum has got to the MIND bungalow.
		Yes	Outcome	3. Mum is OK and has moved on at the moment. HV felt situation improving, mum coping.
		Yes	Outcome	4. Mum has chest pain problem, may be related to contraceptive injection.
		Yes	Process	5. HV felt that all she needed to do was to ring client in a month and leave it at that.
		No	Outcome	6. HV thinks that if mum feels low again she will either get in touch with HV or GP.

Site B Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	7. Husband talking about having a vasectomy. Parents now talking to each other.
2.91.2	6	Yes	Process	1. To do child's 18/12 developmental check now family have moved house.
		Yes	Process	2. To see how family has settled into new home.
		No	Outcome	3. Mum functioning well and is OK.
		Yes - Partly	Outcome	4. (HV felt she needed to check on 18/12 month old's speech and will call in 3 months time - shared) and will use this as an opportunity to check on mum's wellbeing.
		No	Outcome	5. Mum still has quite a lot of bitterness towards her ex-husband and his family.
		No	Outcome	6. In terms of mum's mental/emotional well-being - "She has gone a long way to coping with all that's happened but I still think that she's - she is vulnerable".
2.91.3	7	Yes	Process	1. To do twins 18/12 developmental check.
		No	Process	2. To monitor the situation.
		No	Outcome	3. Mum seemed quite hostile at the beginning of the visit, but then she settled down - HV felt that mum may have been inhibited by observer's presence.
		No	Outcome	4. Mum has made an effort in both her appearance and in tidying up the house.
		Yes	Outcome	5. 18/12 twins development progress is OK.
		Yes	Outcome	6. Will do squint check at a later date, as little girl "was obviously unwell."
		No	Process	7. HV has decided to wait until the children start playgroup in January before she makes another visit in February. Then once they've been seen by people from the Named Playgroup HV will not need to see them for a while. HV wants to go back to see how children have settled in playgroup and keep an eye on things in view of family past history
2.91.4		-	Outcome	HV interview not recorded.

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
3.07.1	10	Yes	Process	1. To see if mum had received a visit from Social Services.
		Yes	Process	2. To check out whether mother had made a self-referral to Social Services.
		Yes	Process	3. To monitor health and welfare of young children.
		No	Process	4. To look at the health of the young girls who are baby sitting.
		No	Outcome	5. Mum strained and angry with Social Services.
		Yes	Outcome	6. Feels mum is ready and willing to go along with any help offered to her i.e. family centre or other support.
		Yes	Outcome	7. Feels that 2 1/2 year old would benefit from going to a playgroup so that she can learn to mix and socialise with children of her own age.
		No	Process	8. HV will reinforce to Social Services mother's need for Family Centre attendance and help with playgroup fees.
		Yes - Partly	Process	9. The family's needs are the same as when she first met them. HV has identified needs, made referrals, but Social Services not forthcoming and she will continue to visit and ("continue plugging away" for services). Feels mother's needs have been side-stepped.
		Yes	Process	10. Asked to see client again - arranges a visit in a month's time.
3.07.2	11	Yes - Partly	Process	1. HV wants to find out what is the latest regarding child's FTT. (Term FTT - not shared with parents).
		No	Outcome	2. The visit was the first time she has felt less alarmed about the family situation as child is going to be investigated by paediatric consultant.
		No	Outcome	3. HV is gathering information which is not stacking up - but worried she might be wrong. Worries that the paediatrician is so experienced.
		No	Outcome	4. She feels she would like to take client on face value - but there comes a point when one has to accept things are not right.
		No	Outcome	5. Fifteen month old is failing to thrive and HV can't ignore this or walk away from the family.
		Yes - Partly	Outcome	6. Lack of other investigative results coming to fruition-shared (indicate mother's inability to feed fifteen month old and her need for support in this - not shared).
		Yes - Partly	Outcome	7. (HV is getting increasingly concerned about the child's situation, as his weight has "dropped dramatically down off the centiles since being referred to hospital" - shared) suggesting that things are not what they appear to be. HV is seeing many contradictions and this is causing her concern - not shared.

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	8. Situation is very complex and HV does not understand what is going on in the family - it is raising many questions for her.
		No	Outcome	9. "I just wonder is this [mum] shouting for assistance?"
		No	Outcome	10. There were more positive aspects to the visit than on previous occasions.
		Yes	Process	11. Asks if she can see client in three weeks.
3.07.3	2	Yes - Partly	Outcome	1. (Final visit for episode of increased support - shared with client). HV has helped clients to sort out her social situation i.e. housing and also counsellor. Social Worker trying to get a grant. Partner's job prospects improving. A/N care on-going.
		Yes	Process	2. HV felt that she needed to pass the family over to the next health visitor. Did this and spoke to next HV, and discovered that mum had already got in touch with her.
3.07.4	8	Yes	Process	1. To follow-up what had happened at child's hospital appointment.
		Yes	Process	2. To assess how mum is coping.
		No	Outcome	3. Client (mum) more calm and in control.
		Yes - Partly	Outcome	4. No longer using the apnoea monitor (despite receiving contradictory advice from the Paediatrician and Registrar - not shared).
		Yes	Outcome	5. Client has more confidence, able to consider separating herself from child - 2 yrs 9 mnths following his apnoea attacks.
		Yes	Outcome	6. Mum a lot happier and will seek out help from health services if she needs it.
		Yes	Outcome	7. Reducing contact with family, situation getting back to normality. HV doesn't think she needs to go back too soon.
		Yes - Partly	Outcome	8. (Child - 2 yrs 9 mnths looks a lot better - shared) and that must have boosted mum's confidence.
3.49.1	3	Yes	Process	1. To discuss GP change as client has moved to a different address.
		Yes	Process	2. Decided to transfer client to another HV (no longer first parent visitor) - coping well, supportive partner, bonded - although HV didn't think client wanted to be transferred to a different health visitor.
		No	Outcome	3. Mum is not depressed post-natally.

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
3.49.2	11	Yes	Process	1. To offer mum on-going support.
		Yes	Process	2. To give mum parenting information.
		No	Process	3. Making 4-6 weekly visits because of CDP.
		No	Process	4. Didn't want to start visit by talking about what was worrying her - i.e. 16 month child's diet.
		No	Outcome	5. Consultant is exploring whether a Munchausen by Proxy situation, health visitor thinks it's Failure To Thrive.
		No	Outcome	6. "I think I'm stuck with this family . I feel there's something wrong in her mothering" e.g. HV trying to get information from mother on child's diet and what she's had to eat, but having no success.
		No	Process	7. HV wanting to engage father more as he could be the salvation of the situation - will try and make appointment when he is there (on reflection).
		No	Outcome	8. Would like to have confronted more about the food - but worried about jeopardising the relationship. Doesn't want to undermine client. "It's the unanswered question of all health visiting, isn't it, how you - how you aid the family forward without pushing so hard that they go into reverse."
		No	Outcome	9. HV wanting someone else to visit with her for a second opinion, sometimes dreads what she might find.
		Yes	Process	10. Arranges to see client in a a month.
		Yes	Process	11. Asked mum to keep a food diary for child to show her in clinic tomorrow.
3.49.3	3	Yes	Process	1. To support mum as part of CDP.
		Yes	Outcome	2. Client capable of sorting her own housing situation out.
		Yes - Partly	Outcome	3. Mum still needs increased support, but (HV no longer covers this patch, so will pass to next HV). "If you can fit time in she's worth spending time with she's in need of some if you can manage it"
3.49.4	10	Yes	Process	1. Family getting extra support as part of Integrated Urban Model.
		Yes	Process	2. HV wants to discuss Family Services Unit with family.
		No	Outcome	3. Mum not interested in exploring [Jamie - 18mnth]'s return home (in care elsewhere), so HV backed off subject.
		Yes - Partly	Process	4. Arranged to see mum in 5 weeks time, (drew on her intuition to make this judgement - this aspect not shared)
		No	Outcome	5. The child's health is ok, but "the parents' health is shocking"

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Process	6. The situation is far from good and HV needs to decide whether to refer the family, but she doesn't think they'll take up the referral, dilemma for HV, may consult with Social Services anonymously.
		No	Process	7. Family need more support than she can give, will liase with family's probation officer.
		Yes - Partly	Process	8. Would like to discuss behaviour modification, child's behaviour and tantrums at next visit. There was not enough time at this visit to do this says HV. (Not shared - "If she goes to nursery there will be some other people seeing this child and giving her other experiences" .
		No	Process	9. Will liaise with team leader about the family.
		No	Outcome	10. Client not giving HV visit a priority, but didn't refuse entry Mum had forgotten about the visit. Mum could not stay as was going to sort out a benefit claim.
3.53.1	7	Yes	Process	1. To explore what's happened with client's own mother.
		No	Outcome	2. Mum worried and depressed.
		No	Process	3. Wants to encourage client to talk more (But client doesn't want to talk about some things).
		Yes	Process	4. Will continue frequent visits as this indicates support and someone who cares.
		No	Outcome	5. Mum has poor motivation.
		No	Outcome	6. Mum has no enthusiasm about the child. HV feels she needs to motivate mother in her interactions with child. (Mum has been like this since early days, comparisons made). She needs to build up mum's esteem and see that she gets some pleasure from the child. (Has had no previous concern about mum's care of child)
		Yes	Process	7. HV to contact housing department to chase up new accommodation and will then phone mum.
3.53.2	11	Yes	Process	1. To assess mum's feelings about the care of her nieces.
		Yes	Process	2. To support mum in managing children and their behaviour.
		No	Outcome	3. Mum has a good appreciation of home safety and potential household dangers.
		No	Outcome	4. The sort of mum where you can just pop in and see how things are.
		No	Outcome	5. Relationship with partner seems more settled from the way mum talks about him.
		No	Outcome	6. Partner taking responsibility for family.

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		Yes - Partly	Process	7. HV thinks it's extremely important that she finds out what is happening with the nieces. She needs a clear picture from Social Services. (Partly shared - as HV checks out with mothers that it is alright for her to contact social services). On reflection HV thinks it might have been better if she had contacted Social Services before the visit to find out this information.
		Yes - Partly	Outcome	8. Mum seems to be coping at present (looks better, more relaxed and calmer in herself - shared with client), so HV won't visit for about 3 months. (Says this is important to reduce the risk of client dependency on her visits). But still feels mum needs extra support above core programme.
		No	Outcome	9. HV believes mum will contact her if she needs her.
		No	Outcome	10. Mum not ready to address the issues around 23 month old child's sleep problems.
		Yes - Partly	Process	11. Would like to address children's stimulation more with mother, as children lack attention - (shared - encourages to attend Mother and Toddler group with youngest child.)
3.53.3	5	Yes	Process	1. HV wants to assess how mum is getting on with 2yrs 1 mnth old.
		No	Outcome	2. Mum seems fairly relaxed and laid back with 2yrs 1 mnth old.
		No	Process	3. HV needs to discuss 2yrs 1 mnth olds diet and weight with mum, but because of the house move and her husband's terminal illness she has put this on hold.
		No	Process	4. HV thinks she may need to be more forceful in future in addressing health needs with mother - critical of own practice in this respect.
		No	Process	5. HV can "pop in" to see how things are going. Says she doesn't always have a clear objective but will just "see how things are progressing" particularly with 23/12 olds disability - retroverted knee cap.
3.53.4	7	Yes	Process	1. To assess how mum is coping.
		No	Outcome	2. HV unsure if mum is coping with the demands of the children as she has only moved a short way forward since HV last saw her.
		No	Outcome	3. Mother is very caring towards her children.
		No	Process	4. Will speak to GP about his negative response to mother. May suggest he gives mother a vitamin supplement for her health.
		No	Process	5. HV thinks she will go back sooner to discuss nursery again, but will speak to nursery staff first about waiting times and priorities. Doesn't want to discuss if resources are not available.

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	6. Has put client's name down for a Christmas hamper.
		No	Process	7. Will address 3 yr 3mnths old girl's eating after mum has got through dental health problems. Will put scales in boot of car for next visit. HV did not address the child's eating problems and weight at visit. She recognises that she skimmed over this, as says she was concentrating on mother's health.
3.71.1	11	Yes	Process	1. To weigh child and measure OFC.
		Yes	Process	2. To offer support to parents.
		No	Outcome	3. Client not ready to move on - just wanting to offload and not doing any real thinking. Mum unable to make any changes to her situation at the moment. Very difficult to get her to want to move on at the moment.
		Yes	Outcome	4. Client unable to manage the situation.
		No	Outcome	5. HV concerned that mum says she has started taking drugs again.
		No	Outcome	6. Parents have reverted back into themselves and children stuck in the middle.
		Yes - Partly	Outcome	7. HV concerned about lack of structure and routine for child (2 years) - (wants to continue to observe - not shared).
		No	Outcome	8. Concerns around mother's lack of prioritisation and main concerns surround how she's coping.
		Yes	Outcome	9. Mum wanting HV to give neighbour the OK which is a concern to HV (she's not here for that).
		No	Outcome	10. More concerned about the family than she's been for a long time. Situation getting worse, very concerned about mum' emotional health and will speak to social worker.
		Yes	Process	11. Decided to go back to see family fairly soon in a week's time because of the whole picture of concern.
3.71.2	10	Yes	Process	1. To follow up on sleep problems and the plan made at last time written in Parent Held Record.
		Yes	Process	2. To explore routine and getting child in a stable routine during the day.
		Yes	Process	3. HV will do another ENCAST reassessment at the end of the 8 week period.
		No	Outcome	4. Does not feel parents want to change bedtimes, feels a lack of commitment on parents' behalf. HV feels frustrated because parents say the sleep difficulties are a problem and then do not seem to want to follow through HV's advice when she gives it.
		Yes	Process	5. Will review with mum next week at clinic whether mum really wants to do this work now or leave it.

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		No	Outcome	6. Sorting the sleep problem out is not a priority to parents, parents still in bed on arrival at visit, despite HV phoning them yesterday.
		Yes	Outcome	7. Deep down parents know child is not bad, but he's got into habits they can't resolve.
		No	Outcome	8. No progress being made by HV – conversations not getting anywhere - feels she is ineffective.
		No	Process	9. HV feels she really needs to check out with parents what they're wanting. (Feels she may have been blinded by her own agenda) to sort out the sleep difficulties.
		Yes	Outcome	10. There has been some progress in clients' raised awareness of children's needs - now picking up on some needs.
3.71.3	8	Yes	Process	1. To see what the issues are and what we can do about it.
		Yes	Outcome	2. Mum having a problem accepting there is little nursery provision available at the moment for 21 month old.
		No	Outcome	3. Mum finding it difficult to cope with the demands on her at the moment and wanting support so that she can actually spend more time with her premature baby daughter.
		Partly	Outcome	4. HV changed her view about mum wanting a nursery place - she seemed to want it for the right reasons - focus on children's needs and not herself.
		Yes	Process	5. HV again checked out with mum towards the end of the visit about having a play worker visit the home.
		No	Process	6. Would like to see mother's interaction with daughter again - feels that mum's interaction with 8 month baby is different from older boys. Will do a visit to see how mum is getting on emotionally.
		No	Outcome	7. On reflection HV should have said she would return with play worker to introduce her to mum.
		Yes	Process	8. Will recommend a nursery placement for the 21 month old.
3.71.4	7	Yes	Process	1. To make an assessment of child's sleeping patterns and behaviour.
		Yes - Partly	Outcome	2. (Mum had decided that 9month baby's sleep was disrupted as teething at the moment - Shared). Mum not distressed as in clinic - not a problem for her. The baby's rash seemed more important - not shared.
		No	Outcome	3. Client not ready to work on getting baby in to a better bedtime routine yet. Client wants to wait until baby's stopped teething.
		Yes - Partly	Outcome	4. (Mum seems to be aware of baby's needs - shared) and her own needs.

Site C Visits	Judgements reported by HV	Client aware - HV judgement shared with client	Judgement relating to process or outcome	Health visitor professional judgements
		Yes	Outcome	5. HV will not visit again unless client requests it, encouraged client to contact health visitors when she was ready to work on managing sleep routine.
		No	Outcome	6. Felt it would have been useful to have known client beforehand to draw on background knowledge of the family. Will liase with client's named HV and suggest that HV rings her in a months' time to check out if there's any questions about information in the Birth to Five book HV will send.
		No	Outcome	7. It would have been best if own HV did visit who has personal knowledge of family.

Appendix 9.1 – **Knowledge in Use**

Knowledge in use	Site A 21 Home Visits	Site B 19 Home Visits	Site C 16 Home Visits
Child growth and development	15	19	16
Child behaviour	13	13	11
Home safety/personal safety	4	11	11
Play and stimulation	6	6	10
Sleep issues	11	11	11
Immunisation	5	7	7
Toilet training	4	4	4
Local facilities	17	17	15
HV services	8	5	9
Dental health		9	3
Infant feeding	13	13	9
Ailment management	8	4	9
Parenting	3	6	4
Child protection procedures	2	2	1
Drugs – Illegal		1	1
Support/lack of	15	9	10
Support to others	2	1	1
Nutrition	5	6	8
Mental health promotion	6	5	9
Social aspects of health	5	1	4
Baby care	4	7	6
Pathology	6	4	8
Smoking		1	1
Maintaining health	10	9	8
Medication	11	7	5
Other treatments	8	7	6
Family relationships	8	10	6
Death, dying and bereavement	1	1	1
Benefits/finances	3	4	4
Physiology	12	9	4
Screening tests		2	1
Psychology	2	7	5
Existing knowledge of client/family	19	18	16
Family past history	4	7	6
Housing	9	3	3

Appendix 9.2 – **Health Visitors' Experience of Gut Feelings**

Client	Initial HV assessment	Observed visit
1.15.1	No	No
1.15.2	No	HV and client discuss client's vibes
1.15.3	Yes, chaos, what is going on here?	No
1.15.4	No mother's anxiety very obvious	No
1.25.1	No	Yes, HV picking up different message from what's said
1.25.2	No	No
1.25.3	No	Client feels handicapped child unwelcome by family
1.25.4	No	No
1.39.1	No	No
1.39.2	No	Yes, feels that mum thinks her baby doesn't like her
1.39.3	No	No
1.39.4	No	No
1.39.5	No	No
1.70.1	No	No
1.70.2	No	No but says 'feeling' important in determining child abuse risks
1.70.3	No	Client describes her own mothering instincts
1.70.4	No	No
1.82.1	No	No
1.82.2	No	Unsure whether a 'feeling' or an unanswered question
1.82.3	No	Yes - HV thinks she has to tread carefully with mother
1.82.4	No	Yes feeling linked to reflection on the situation
2.06.1	Yes	No
2.06.2	Slight niggle - mum young/on own	No
2.06.3	No	No
2.06.4	Yes	Moved on from intuition HV has more awareness now
2.20.1	No	No
2.20.2	No	No
2.20.3	No	No
2.20.4	No	No
2.38.1	No	No
2.38.2	No	No
2.38.3	No	Yes - vibes

Client	Initial HV assessment	Observed visit
2.38.4	No	No
2.77.1	No	No
2.77.2	Yes	Yes combined with factual evidence.
2.77.3	No	Yes when HV saw client in clinic and arranged the visit
2.91.1	Yes	No
2.91.2	No	No
2.91.3	No	No
2.91.4	No	Health visitor interview not taped
3.07.1	No	No
3.07.2	Yes anxieties - alarm bells ringing	Yes anxieties and alarm bells ringing
3.07.3	No	No
3.07.4	No	No
3.49.1	No	HV talks with client re trusting her mothering instincts
3.49.2	Yes combined with anxiety	Yes combined with anxiety
3.49.3	-	HV encouraged mother to rely on her instincts about her child
3.49.4	Yes	Yes, combined with personal worry
3.53.1	No	No
3.53.2	No	No
3.53.3	No	No
3.53.4	No	No
3.71.1	No	Gut feeling, sensed something which led to immediate recognition of a problem
3.71.2	No	HV picking up vibes that she is isn't helpful; family think she is
3.71.3	No	Gut feeling initially, on reflection HV felt based on observation
3.71.4	N/A	Yes but on analysis a response to what heard and saw

Appendix 10.1 – The range of needs presented by clients and the families in the study

(As reported by the health visitors – pseudonyms used)

Single, one-off contact by health visitor
A response to a client's expressed need (or single problem/need)

1.39.4 – Mum requested visit because of the worsening pigeon situation.

3.71.3 – Parents came to clinic requested help with older children's behavioural problems.

To see what the issues are and to find out what 'we' can do about it.

3.71.4 – Mum called in to clinic as experiencing difficulties with 9 month old baby's sleep problems.

Short term extra input for time limited period
Actual or potential health difficulty or temporary family dysfunction.

**Potential needs identified
@ needs recognised by client

1.25.4 – Mum had the potential to suffer from post-natal depression **

1.39.1 – HV concerned about how mother is coping with 2 year old since new baby's arrival**

1.70.1 – Triplets and to observe mum's bonding with babies.**

2.06.2 – Mum contacted HV with multiple needs – mum's relationship difficulties, her past abuse, step-father being released from prison later next year, financial problems.@

2.38.1 – Maternal depression. @

2.38.2 – Baby premature, could not tolerate formulae milk. Now 8 weeks old. Mum anxious about having baby at home as had an apnoea attack two weeks ago.@

2.38.3 – Baby premature, in SCBU over 50 days, has conjugated bilirubinaemia. On oxygen therapy. Mum had the potential to suffer from post-natal depression or bonding difficulties.**

2.38.4 – First baby – mum breast feeding. Mum has had a caesarean section.@

2.77.2 - Mum in tears coming out of GP surgery, mum tired, vulnerable and very anxious about 18 month olds bout of D and V and viral infection.@

2.77.3 – Mum very isolated, vulnerable, marriage in tatters, mum's concerns around child (2 years 3months) and forthcoming major cardiac surgery.@

2.91.1 – Mum suffering with depression and panic attacks – disclosed history of sexual abuse as a child.@

3.07.3 – Multiple needs expressed by client. A lot to cope with, mum pregnant, with second baby, mum very young, up and down relationship with partner, living with relatives, vulnerable young couple, previous social services involvement, mum terrible childhood, previous sexual abuse by an uncle. @

3.07.4 – Mum's lack of self-confidence and $2^1/2$ year old child's recent apnoea attacks and asthma. @

3.49.1 – First time parents as part of CDP.**

3.49.3 – As part of CDP, mother's self-care poor in terms of diet and constipation.@

3.53.4 – Concerns around mum's health, she is an older mother. Still breast feeding two children, now a single parent.@

3.71.2– Parents wanting help managing 2 year old son's behaviour.@

Intensive visiting and support for client/family – initial assessment stages
Acute health difficulty or temporary family dysfunction.

1.39.2 – New birth visit, mum extremely stressed. First baby breast feeding on demand. Mum desperate for sleep and baby feeding erratically. Mum in tears finding it difficult to cope. Potential concerns about mum's mental health - query early post-natal depression.

1.82.1 – HV still gathering information about the family. Mum very angry with social services. Multiple problems in the past, which are impacting on the present. Both older boys on the CPR for physical and emotional abuse, deregistered at case conference last week. Mum wanted to talk to HV about oldest boy's (13 years) behaviour.

2.06.1 – Mum depressed, not sleeping, multiple problems. Boyfriend chased by drug dealers to her house. Finding it difficult to cope with 18 month old daughter. Uncertainty and dangers associated with current situation.

2.06.3 – Mum had a very difficult birth and delivery. Fourth baby. Very large baby 5.56 kg. Mum low and suffering post-natal depression.

Long term support – health visitor maintains intermittent contact with client/family as specific needs arise.

1.15.1 - Special needs child

1.25.2 - Special needs child

1.25.3 - Special needs child

1.39.5 - Special needs child

1.70.3 - Special needs child

2.06.4 - Special needs child

2.77.1 - Special needs child

3.53.3 — Special needs child and father had terminal cancer

Long term support – frequent, regular and ongoing contact with client/family.

Client/family with multiple health and/or social needs / problems. Needs continue to surface and/or are ongoing. Sometimes chaotic and unstable family situation.

1.15.2 - Multiple problems. Mum has borderline learning difficulties. Expresses problems but can't work out the answers for herself.
Support has been on going with each stage of 3 year old's development and mum's lack of confidence.
Social services involved last year because of complaints by neighbours that she's been manhandling 3 year old when with boyfriend.
General harassment and victimisation by neighbours.

1.15.3 - Multiple problems. Mum had been admitted to a psychiatric unit with puerperal psychosis after each baby. Social services had been involved. Mum unable to cope with middle child (3 years 7 months). He lives with maternal grandparents.
Mum has limited grasp of parenting responsibilities – fairly oblivious to children's needs.
Mum met boyfriend while she was in hospital. He's a schizophrenic.
2 year old's speech development is delayed.
History of social services involvement, had had a lot of needs in the past.

1.15.4 - Anxiuos older first time mother – needs continue to surface e.g. Mum initially concerned about how she was going to cope with baby and has continued to have concerns around weight gain and infant feeding, 10 month old baby currently has a sleep problem, which is improving,

1.25.1 - Husband on remand for benefit fraud. Mother is pregnant. No benefits for family because they are being investigated for fraud. Concerns about mother's mental health in view of circumstances and basic physical health of the family. Concerns abut mum's health, she is 20/52 pregnant.

1.39.3 - Mum has rheumatoid arthritis. On going difficulties. On anti-inflammatory and anti-depressive drugs. 9 month old has been a difficult baby, always ill and has had immunisations delayed. Lack of support from Mum's husband. Older children's' behaviour demanding.

1.70.2 - Long history of family problems. Mum on Prozac for some time. Mum came off Prozac and is trying to reduce her cigarette consumption. Social Worker left a month ago. HV had asked Social Worker to contact housing to get mother rehoused in this area, as now stable and settling into the area. Family (mother and 6 children) currently living in temporary accommodation.

Mum has had a long history of problems. She was sexually abused by her brother and feels a lot of anger towards him. Father very violent and used to beat her every night. Niece admitted to her that she was abused also. The niece has now told her mum, who'd reported it to the police and a case is now pending.

1.70.4 - Multiple problems. Mum has a history of depression and difficulty bonding with her daughter now 15months. At one stage mum suicidal post-natally. Baby underfed. Low weight. Mum finds developing emotional attachments difficult with both her child and her husband.

1.82.2 - Multiple problems facing family. Four children under 8 years of age. 6 year old's behaviour problems and mum's negative attitudes towards him. Mum depressed and finding it difficult to cope with the demands of her new baby (now 11 months). Baby had feeding problems, then admitted to hospital with gastro-enteritis. "There seemed to be multiple things going on all the time". Mum finding things a strain. Father possibly undergoing orthopaedic surgery shortly.

1.82.3 - Multiple problems. 4 children. Mum had eldest daughter (9 years) as a young unsupported, single parent. Mum abused her and she was on the CPR and was made a ward of court. (Emotional and physical abuse). 9 year old daughter still causes mum concern about not growing, she is short in stature, and child also suffers from eczema. 9 year old had oral steroids when younger and this may have been an inhibitor on her growth.

Dad is a depressive and attempted suicide last year after his mother died. On anti-depressants.

Mum was "holding it all together" - she suffered child abuse by her father and hasn't got a lot of her own resources. Does not show too much insight into her own life, concerns about how she is coping with all the children and her own parenting abilities. Concerns around mum's negative attitude towards 5 year old son.

1.82.4 - Mum had post-natal depression and on anti-depressants. Has also had severe back pain and had an operation on her knee.

2.20.1 - HV has "known this mum for years". Mum could not read until she was 14. Then learned to read but could not write and very self-conscious about this. Mum living in a homeless hostel when HV first met her. She came to City with her boyfriend who then deserted her from another City in the South. Father violent to her. She has dyslexia. HV helped her to fill out the forms to be rehoused. Concerns that mum would go back to other city, she was in homeless accommodation for a long time. Somewhere a long the line she moved into a flat. She had a Homestart visitor who stayed with her during her labour. Mum then changed HV's and GP's. Mum reported that previous HV had said to her "people like you have no right to have children" and so mum then transferred back to current HV. Had another baby with her boyfriend and then boyfriend left her. She is waiting for a council house exchange to a different area of the country - could take years. Mum worried about 4 year old and the possibility of him being dyslexic. HV referred him for a Special Assessment and he's now being statemented.

2.20.2 - Mum came to HV worrying if there was something medically wrong with 3 year old. HV referred child for a Special Assessment. Child is functioning 9 months in advance of her chronological age, her IQ being 26% above average. Her mum has run out of ideas and does not know what else to do for the child to meet her demands in learning. There are a lack of state nursery facilities in the area. Could be a potential child protection issue. 3 year old girl a demanding, bright child. No facilities in city for bright children.

2.20.3 - On-going problems. Eldest child (9 years) initially on CPR because physically abused by step-father. Because of previous SIDS - family went on the CONI scheme. HV wearing two hats with the family CONI - weekly visits for 6 months and CPR.

"My worry is obviously about CPR for both [9 year old] and [3 year old] and perhaps [18 month old] as he gets older." Family have been left unsupported. 3 year old now attends a Local Authority nursery, he's a very demanding child.

9 year old girl's weight gain is also poor and the school nurse is supposed to be monitoring this. At the last two school medicals, she has been off sick. 9 year old's grandfather died a year ago and she has seen a counsellor at school.

2.20.4 - HV has known mother since she was 16 and pregnant with her first baby. Multiple problems. 4 children. Visited mother in various homeless hostels as they wouldn't give her a council flat. Eldest child on CPR for FTT in December 1990 aged 6 months, as mother unwilling to accept help or see the need for it. HV always been worried about him (now 7 years). Health visitor has had several calls from people who were worried about parenting of eldest son. Partner - dropped him down some concrete stairs in 1992 and he was in hospital, he was discharged four days later. Consultant concerned that the child was exhibiting 'frozen awareness' and there was another case conference, in early 1993 and social services reviews held in March, 1993, November, 1993, but still the child was not registered as mother would not accept any workers. Mum won't work with anybody except HV. Oldest child is now being statemented for special educational needs. HV doesn't believe a word partner says "he threatened to put a bomb under the GP's car and she threw him off the list." On-going chronic family problems. Mum is a heavy smoker 30 plus a day. Overweight. Suffered with post-natal depression in the past.

2.91.2 - Supporting mother through various life crises. Her husband left her during the early weeks of her second pregnancy because he was having a homosexual relationship.

2.91.3 - Single parent. 7 children, the two eldest don't live at home and they have both had babies recently. HV says "family has had masses of social services input." Eldest daughter disclosed in the past that she'd been sexually abused by a man she worked for part-time and she went on the CPR in 1991. Previous HV had passed comment about her at a Child Protection Conference and her name went on the register. Mum was furious and asked for a change of HV. When the twins (18 months) were first born there were a few planning meetings and they had a home care worker for some time. The organiser from Homestart had recently sent social services a letter of concern about the family.

2.91.4 - Parents needing a lot of guidance in parenting. Youngest daughter was referred to the paediatrician at the city hospital and was admitted in May 1995 for FTT (aged 6/12), for an assessment and had various investigations, including a sweat tests. HV sees family regularly. Youngest daughter's 8/12 check OK. At 18/12 she demonstrated delay in social and manipulative skills - so HV referred for a Special Assessment in September and child found to have a mild-moderate delay. Child referred to Early Stimulation Project and the Opportunity Playgroup.

3.07.1 - Multiple issues. HV "heard" via anonymous phone call "children naked in the window". HV has concerns but sometimes does not know why she goes. A procession of young school girls looking after the children. Police visited the house last Wednesday and social services last Friday. Social Services recognise family needs "help and support" and want to do some work with mum regarding parenting at a local family centre. Mother's best friend has just handed over her second child to social services and her previous child was also taken into care.
Previous history of violence from ex-husband.

3.07.2 - Child's failure to thrive. Child (15 months) has had investigations for cystic fibrosis - no conclusive results yet. Referred to hospital in March 1996 (now Sept. 1996). House dirty and in a mess. Possible child protection concerns.

3.49.2 - Because of 16 month old child's continued failure to thrive. First child. HV referred to paediatrician in March. Mother requires on-going support from HV because of child's failure to thrive and in the enhancement of her parenting skills. Query harming child. Child has had 4-5 fits which nobody has seen. Child admitted to hospital 3 times for investigations – inconclusive.

3.49.4 - Multiple problems. Family vulnerable and needing extra support. July 1996 family became HV's responsibility again.
Increased support on IUM. Dad was still in prison because of drug dealing. Mum virtually homeless, lost cooker and everything – home vandalised and the furniture taken. Mum in a "shocking state"- pale, looking ill and sad. Eighteen month old not with her, had been taken on by father and step-mother. 2 1/2 year old girl being cared for a lot by her sister and her mother.

3.53.1 - Abuse and violence from the father of her child. Multiple and on-going needs/problems. Mum recently took an overdose and went to the city hospital and was admitted overnight. Things got on top of her. 1) Mum previously abused by her father sexually. 2) This incident. (Partner had beaten her up whilst she was pregnant). An investigation has been set up. Her sister has also been sexually abused by their father, she is 14 years. Father has now been arrested. On remand and now on bail, living in a hostel in a local city.
Mum's been given a house, which will be ready in October. A lot of aggravation between Mum and her mother and father. Mum's mother has thrown her out and she's staying temporarily with her sister.

3.53.2 - Came across when covering another HV's caseload last year and mum had fled to a refuge hostel in a local town after family violence. Oldest child (then 7 years) dropped the baby (then 5 months) in the hostel and baby sustained a fractured skull. So HV made contact and visited the family at home in late March and had no concerns about mother's care of the children. (HV knew about this from HV covering the women's refuge in local town). Mother then called HV 2 weeks later, mother unstable, drinking, mother questioning her own abilities to care for the children. Violence had erupted again and her partner had gone. Volatile situation. But father never violent towards the children reported mother. HV keeps in frequent contact with family because mother is on her own in a relationship that is up and down. HV unclear about partner's support. There is also some involvement with partner's nieces. Mum looks after them. (Their father has a drink problem.) HV has referred nieces to social services (girls age 7 and 10 years). Mother reported that one of the girls said she was bleeding PV.

3.71.1 - Parents have previous mental health problems. New baby has hydrocephalus. Parents' parenting skills are limited and mother appears to have difficulty putting things in to practice. Mother has started taking drugs again.

Appendix 10.2 – The range of factors considered by the health visitors when determining a family's need for increased support

Factors considered by health visitors in their assessments.	Initial Assessment	Current Assessment
Parenting concerns	23	20
Lack of support	15	19
Finding it difficult to cope with children's needs	16	17
Parents have actual or potential mental health problems (also history of)	20	15
Client requested visit/help	13	15
Child's development delayed	7	14
Child development problems/special needs	9	13
Children's behaviour problems	10	12
Maternal health problems	8	12
Problematic family history	13	10
Potential child protection concerns	4	10
Recent social services involvement	11	9
Housing difficulties / poor conditions /chaotic household	8	9
Child's health problems	3	9
Mum very tearful and emotional/tired	12	8
Relationship with partner broken down	9	7
Maternal vulnerability	7	7
Mum very anxious	7	7
On anti-depressants	8	6
Mother lacks confidence	6	6
CPN/Counselling	4	6
Relationship difficulties with family members/close friends	7	5
Up and down relationship with partner	7	5
Mum - young mother (parents)	7	5
Child Feeding Difficulty	5	5
Lack of bonding	5	5
Financial problems	3	5
Abuse - P (Physical) / S (Sexual) / E (Emotional)	P-4, S-6	P-2, S-1, E-1
A lot to cope with	7	4
Weight plummeting / FTT / poor weight gain	5	4
On Child development Programme	4	4
High expectations/unrealistic expectations/negative attitude	4	4
Living with extended family/friend	3	4
Bereavement	2	4
Mum's self-care poor e.g. diet	3	4

Appendix 10.2 – The range of factors considered by the health visitors when determining a family's need for increased support

Factors considered by health visitors in their assessments.	Initial Assessment	Current Assessment
Very difficult delivery/pregnancy/CS	8	3
Mum and/or parents smoke	3	3
Child asthma	3	3
Twins/triplets	3	3
Wanting child in care temporarily	2	3
Mum pregnant	2	3
Baby has hydrocephalus	2	3
Partner unemployed	2	3
History of violent partner	7	2
On list of concern families	5	2
3 children under 6	5	2
Breast feeding	5	2
Single parent	3	2
First time parents	3	2
Lack of insight/lack of resources	3	2
Maternal diet very poor	2	2
Recent police/probation service involvement	2	2
Family under a lot of pressure	2	2
Neighbours increasing referrals of family to other agencies	1	2
Mother lacks awareness about safety issues		2
Drug taking		2
GP or SW alerted HV about difficulties	6	1
HV knew of extended family problems	2	1
Mother lacks understanding /find things difficult to put into practice	1	1
Uncertainty of situation	1	1
Maternal drink problem	1	1
Mum - overweight	1	1
Mum main carer	1	1
Mum - can't get to clinic much	1	1
Husband CA Lung	1	1
Young girls looking after children	1	1
New baby breast fed and 2 year old - mum wanting to stop breast feeding older child	1	1
Child ill diarrhoea.	1	1
Friend's children both in care	1	1
May not take up nursery place for child	1	1
Mum anxious about child's constipation	1	1
Run down / poor area	1	1
Child has UTI		1

Appendix 10.2 – The range of factors considered by the health visitors when determining a family's need for increased support

Factors considered by health visitors in their assessments.	Initial Assessment	Current Assessment
Maternal vulnerability has taken OD		1
Looking after extended family		1
Family's needs unacknowledged by other agencies		1
Mother living dangerously		1
HV wanting to refer to SS, mother not in agreement		1
Child cared for elsewhere		1
Physical health of family		1
Bullied at work		1
Referred by previous HV raising concerns	8	
Mother despondent	5	
Husband awaiting nephrectomy	1	
Referred by HV covering women's refuge	1	
Harassment from neighbours	1	
First husband dead	1	
Mum - elderly in 40's	1	
Family find clinic attendance difficult	1	

Appendix 10.3 – **The Approach Adopted by Health Visitor 1.15 at Each Client Contact**

Client	Client View	Apparent health gain?	Observer View
1.15.1	Client still worried about child's ear infections. Client feels HV understands her emotional state and it was helpful to discuss the housing problems and her bereavement. HV gives . her support	HV offers client lot of reassurance about child's repeated ear infections. Client able to talk about her recent bereavement, grandfather's death and funeral arrangements. HV also provided client with information and reassurance about anonymous calls/concerns being on a SS file.	**Very facilitative.** Despite client's friend being present. HV demonstrates empathy and sensitivity to client. Addresses needs raised by client and positively reinforces client's actions. HV changes subject to explore housing situation at an appropriate point in the conversation (her agenda). Uses affectionate terminology when speaking with client "love" and "my dear". Feels she's adopting a mothering role with client.
1.15.2	Very positive - found it extremely helpful. It made mum feel a lot better, likens it to speaking to a psychiatrist - "empty your system".	Reassurance to client about child and her developmental progress. HV arranges to go and speak to nursery with mum about child's assessment and report from paediatrician. Focus is very much on supporting the parent of a child with special needs.	**Very Facilitative.** Overall a sensitively conducted and facilitative visit by HV. Addressed needs raised by client as well as addressing her own agenda. Lots of empathy and listening evident. Focus is very much on supporting the parent of a child with special needs. Reassurance ++ that child's problems are not a result of mother doing the wrong thing. HV talks to client in sensitive manner "my love".

Client	Client View	Apparent health gain?	Observer View
1.15.3	This client really does not want or feel the need for a health visitor. Client does not percieve the need for HV service, wanted to tell HV not to call again, but didn't. Likes HV but does not want a HV. Had a bad experience with her previous HV who referred her to social services. Client had been reluctant to let us in as she and her mother were worried people think she's an unfit mother, feels her post-natal illness is being held against her. Feels HV and Family Centre interfered too much with her past life.	Nil, client feels that HV asks the same questions now as the first time she met her. Thinks if HV wasn't encouraging her to have child's MMR done it would be something else "there'll be something else on the agenda". HV feels its very negative, she says "You're almost in a no win situation. You know you can't persuade them to actually do anything meaningful and so you're not actually achieving anything for that child and if you really push too hard they'll really you know shut you out completely and it's, it's very difficult". HV doesn't feel she is making any headway with this client. Mum starting to dig her heels in. HV aware she has suggested things i.e. MMR (which HV raises x4 and even offers to do at home) and nursery place at Family Centre (x3) that mum is not happy about. Thinks mum's going to start putting up barriers. HV doesn't think client understands what she is trying to do. May have to back off. Feels she's in a no win situation.	**Ineffective.** Client does chat very readily to HV throughout visit, although towards the end she seems less enthusiastic about HV's suggestions i.e. to return in a month's time - "mm" and for child to attend the family centre. Although there is evidence of HV trying to raise mother's awareness about safety issues in the home and providing information about local GP's. HV doesn't feel she is making much progress with this family. This is supported by mother's comments which are very negative about the HV service. HV is clearly trying to assess any risk to the children and father's access arrangements. Mum calls HV the wrong name throughout the visit and HV does not correct her. HV changes the subject 15 times during the visit, using a questioning approach. Evidence of HV coercing client to get child's MMR done. Also she is rather directive twice during the visit. Uses affectionate terminology when speaking with client "my dear" and to child "sweetheart".
1.15.4	Feels the advice that HV offered at last visit for managing baby's sleep problems has helped.	Child's sleep problem has improved significantly in a week, now not waking routinely at night. HV reinforces the progress that mum has made in dealing with this need.	**Facilitative.** End of an episode of increased support. Conversation flows between mum and HV. Not a great deal happens during the visit other than HV asks a lot of questions to evaluate progress with baby's sleepng and reinforces the progress that mum has made with this need.

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